

# Migration as a policy response to population ageing

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## Introduction

Migration as a means of addressing population issues has – either directly or indirectly – always been a tool to hand. More specifically at the international level, replacement migration was first introduced by the United Nations Population Division as a mechanism whereby one could address perceived imbalances in population structures brought about by population ageing, which arises from declining fertility and mortality (Leeson 2004; United Nations 2000). While replacement migration has been shown to be demographically unrealistic, the discourse in this field has still focused internationally on the role of migration in replacing labour shortfalls and skills shortfalls.

This case study will consider the role of migration – and in this case migrant carers – in addressing the provision of health and social care for older people in the United Kingdom in the light of dramatic population ageing, and will present the case from the point of view of the sector primarily.

Demographically, the United Kingdom is a typical example of an ageing population for which ageing also has consequences for its work force – and in particular the health and social care workforce, which finds itself under massive pressure from the small recruitment cohorts, recruitment and retention problems, and the growing demand for services from the ageing population. The statistics reveal quite clearly this pressure and the drive to recruit health professionals internationally to meet the staff shortages. Increasingly, certain areas of the health and social care sector have become dependent on foreign workers – both those recruited internationally and those already resident in the country, choosing to qualify in the sector. A separate – and equally important issue – is the funding of care (Commission on Funding of Care and Support 2011), which indirectly impacts on the health and social care workforce and its composition and level of qualification, which then in turn impacts on the quality of care.

The migrant carer mechanism as a solution to this situation was both intentional and unintentional. On the one hand, migrants were being recruited into the care system and on the other hand, migrants were finding employment in the care services without having migrated for this specific purpose.

*Intentional:* in certain areas NHS Trusts engaged a specific policy to recruit foreign nationals to fill skills gaps and ensure the provision of services to the ageing population.

*Unintentional:* recruitment of care staff into home care agencies and into care homes was in many areas dominated by migrants.

The result of this mix was indeed one of migration as a response to population ageing, and part of it was a formalised and conscious organisational policy structure for recruitment.

The case study is based on work by Leeson & Harper (2004), and by Cangiano, Shutes, Spencer & Leeson (2009).

### The case study

- Outlines a picture of concern about the language and communication skills of overseas workers in the health and social care sector in the United Kingdom
- Reveals genuine concerns about improving the training programmes designed to acclimatise overseas workers to the UK and to working in the UK culture of care
- Highlights the specific focus on providing language and communication competencies related to working in the health and social care sector in a multicultural society such as that in the UK
- Outlines new strategies for specialised recruitment of international nurses rather than recruitment campaigns focusing on target numbers
- Reveals a dedicated internationally recruited healthcare workforce whose language and communication deficiencies are outweighed by their contribution to a sector under pressure
- Underlines the pressure on the health and social care workforce and the role of migrant carers in addressing this issue.

## Part 1 - The risk and the background

So what is the risk and how did it develop?

The risk is quite simply the potential inability of the private and public sector to meet the future demand for health and social care of older people.

This is in some sense an absolute risk (i.e. a numbers game) and a quality risk (i.e. assurances of the quality of care on the one hand and workplace conditions for migrant carers on the other hand).

The development of this risk is driven by an increasing number of people living longer lives and therefore an increasing number in need of long term care combined with a health and social care workforce which is low status, low paid and predominantly female, which in turn impacts on recruitment and retention.

The increasing demand for care has been driven by the changing demographics and behaviours of family – fertility levels have declined dramatically and families have become smaller (with therefore potentially fewer family carers) and families (i.e. females) are at work (leading to implicit pressure on female family carers struggling to maintain a work-life balance dominated by a caring role: the sandwich generation).

Despite guarantees to up-skill the care workforce and make this sector more attractive, it has remained an unattractive predominantly female sector with significant problems of recruitment and retention.

The population of the United Kingdom is ageing as a result of declining fertility and mortality in the 20<sup>th</sup> century and as a result of continued low levels of fertility and mortality in the coming decades. It is expected that the proportion of the population aged 80 years and over will rise to more than 9 per cent by 2050, and that of those aged 65 years and over to 24 per cent, compared with less than 5 per cent and 17 per cent in 2010 (United Nations 2010). In absolute terms this is an increase in the number of over 65s from around 10 to around 17 million and an increase in the over 80s from 3 to almost 7 million. This demographic development in its own right has of course significant implications for the future demand for the provision of health and social care for older people and for the future demand for the workforce to provide this care. Add to this, as mentioned, the increasing pressure on the (smaller) family where fertility levels have declined from 2.8 in the early 1960s to 1.9 today.

Long term care for older people in the United Kingdom remains in the main the realm of the family in an environment of a policy focus on community rather than institutional care so that family care in the home is sometimes combined with formal, paid support services. But will there continue to be a sufficient source of family care? This is most certainly a key question underlying the future demand for health and social care workers in this ageing population of the United Kingdom. Low pay and unsocial working hours add to the context in which the composition of the future social care workforce will be shaped.

Within the formal health and social care sector in the United Kingdom, migrants (people born abroad) comprise already a significant proportion of this predominantly female workforce – around 15 per cent of the formal care workforce as a whole. In some areas, the migrant proportion of this workforce is even more striking – more than 50 per cent in London and the South East.

Some migrant carers have entered the United Kingdom on work permits to work in the care system while others – for example, those who entered as family members or as European Union citizens from Central and Eastern Europe – have entered the care workforce as the easiest point of entry to the labour market in the United Kingdom.

Will migrants still be available in the coming years to enter the care workforce? If so, what are the issues facing this policy? Will policy shift and focus on the training and recruitment of care workers born in the UK? In both cases, the numbers game remains an intrinsic element of the issue.

This increasing demand for social care services and the cost of providing these services has over the years prompted a series of political and policy debates and policy initiatives in regard of the future of long term care, most recently with the publication of the so-called Dilnot report in 2011 (Commission on Funding of Care and Support 2011).

The correlation between policy towards the entry of migrant workers on the one hand and policy on the provision of long term care and the future care workforce on the other hand is a significant issue.

With the future of the social care system in the United Kingdom in the political eye, the system of entry for migrant workers underwent marked reform. A system with over 80 categories of entry was replaced in 2007-2008 with a five tier ‘points system’ in which the different channels through which migrants have – directly or indirectly - entered the care workforce were replaced with more limited options for entering to work in the United Kingdom. The Government wants workers already in the country or in the European Economic Area (EEA) to fill vacancies in the labour market, allowing access for migrant workers only where vacancies remain.

An integral part of the overall risk outline is the difficulty regarding the recruitment and retention of care workers to meet the future demand for care of older people (Skills for Care, 2008) in an area of ‘chronic difficulties’ (Commission for Social Care Inspection, 2006). There are skills gaps rather than a shortage of applicants (Learning and Skills Council, 2006), and high levels of turnover add to the risk complexity.

This aspect of the risk is driven by a complex set of factors and their interrelations such as the number and type of jobs in the sector and the size and characteristics of the workforce potentially available to move into these jobs. An employer’s perception of motivations, constraints and frames of reference is likely to affect the strategies and practices of recruitment and employment.

The apparent mismatch between demand and supply in the care sector is related to the unfavourable employment and social conditions of jobs in the sector. So low wages, low status, unsocial working hours, insecurity in employment and lack of career opportunities all

work against the sector. Clearly, unsocial working hours are part and parcel of such care work, but other factors may be of a more institutional nature. Many employers in the care sector rely on public funding to operate and may therefore not be able to offer competitive salaries to attract more UK workers. There is also a socially constructed and negative perception of social care work. The perceived low status of jobs in the eldercare sector may be driving jobseekers to other types of jobs with similar wages and working conditions.

Labour demand and supply is not only a quantitative issue. It can also be qualitative in as much as the skills needed do not match the skills available. In the care sector certainly, soft skills can be as important as formal qualifications and this demand for soft skills can become a demand for specific personal characteristics and attitudes.

The *risk* is essentially one linked to the provision of care (quantity and quality) to an ageing population in the United Kingdom. As we shall outline the following, this *risk* is exacerbated by various characteristics of the care workforce related to recruitment and retention which provided an ideal environment for international migration into the workforce (migrants entering to work in this sector along with migrants entering and finding this sector the easiest labour force entry point).

There is thus a *risk balance* to be addressed which arises from the increasing inability of the care sector to sustain its workforce **without** migrant carers on the one hand, and the concerns related too international migration on the other hand.

How was the emerging risk dealt with? In Part 2, we shall consider this risk management empirically.

Finally, the lessons learned and recommendations will be presented in Part 3.

## Part 2 - Dealing with the risk

Why do employers draw from particular sources of labour and why do they need migrant workers?

Employers are usually aware that migrant workers are willing to accept wages and working conditions that are lower and poorer respectively than normally accepted in the host country because these are higher than those they are used to in their countries of origin. This can have an important impact on the preferences of employers with regard to their recruitment strategies.

Studies often reveal an appreciation for the superior work ethic of migrants, which is often no more than a greater willingness on the part of the migrant worker to do the job on the employer's terms, which in turn may be related to the less secure employment conditions, immigration status, or the fact that they may not have family.

Studies also reveal that cultural traits and characteristics are perceived as an advantage of certain groups of migrant workers. Some groups in the care sector are perceived as having a more caring ethos.

These factors all represent reasons why employers may prefer certain groups of migrant workers.

The other element of this risk dimension is that employers identify challenges of employing migrant workers (see cases below). Language skills are the most important drawback, but can also be an important asset – for example, foreign-language speakers working in ethnically diverse areas may possess language skills and knowledge about cultural and religious practices that enable them to work with people using services who share a similar background while UK workers would need training in this area.

So let us now move to the numbers game status as part of the risk. This is a numbers game which is characterised on the one hand by the increasing demand for care and by the ageing of the care workforce, which together have increased the pressure on the sector and on recruitment to the sector.

The United Kingdom has traditionally been relatively dependent on immigrant doctors and nurses in the health and social care sector. Active recruitment from India and the Caribbean in the post-war years meant that by 1967 almost half the junior doctors employed in the health services were immigrants (Rose et al. 1969). From the mid-1980s to the late 1990s, the number of immigrants employed in the health and medical sector rose by almost 50 per cent, more than three times the increase in the number of immigrant workers overall in the same period (Dobson et al. 2001).

The Nursing and Midwifery Council (NMC) plays a central role as far as the introduction of overseas nurses, midwives and health visitors to the UK health and social care sector is concerned. No person may practise as a nurse, midwife or health visitor in the United Kingdom without being registered with the NMC.

The number of persons on the NMC register increased through the 1990s, peaked in 1997 at 648,000, and declined to a low of 632,000 in 2001 since when it increased to 676,000 in 2008 (NMC 2009). Since the early 1990s, the proportion of those registered aged over 55 years has increased from 10.7 per cent to 17.2 per cent by 2008. The largest proportion (around 60 per cent) of the registered NMC workforce is aged 30-49 years.

The ageing of this workforce is clear. In the mid-1990s, more than 50 per cent of the register workforce was aged less than 40 years. Today, 65 per cent of the workforce is aged over 40 years and 31 per cent is aged over 50 years. A recent NMC membership survey (Ball & Pike 2004) confirms the ageing of this workforce, and the prospect of waves of retirement is a serious issue. This will place increasing pressure on the workforce and recruitment to the workforce – and this has contributed to the influx of migrant carers to the workforce.

***Migrant carers have thus been a key element in addressing the risks arising from the combination of the ageing of the population and the accompanying increasing demand for care, the ageing of the care workforce, and the pressures on recruitment to the care workforce.***

The importance of immigrants entering this healthcare workforce is reflected in the fact that of 35,000 initial admissions to the NMC in 2004, 43 per cent were from overseas (incl. EEA countries), but less than 3 per cent (corresponding to just over 1,000 admissions) were from the EEA (NMC 2004).

By 2008, however, only 26,000 initial admissions were registered and of these only 2,000 were from overseas (excl. EEA countries) with a similar number from EEA countries.

*Training* (of non-migrant carers) alone does not guarantee the future workforce. According to the survey, almost 10 per cent of trainee nurses do not intend to enter the NHS, and although the vast majority of nurses spend the first five years in the NHS after qualification, only 38 per cent remain after 20 years.

***International recruitment was perceived as a major element in developing and sustaining the care workforce.***

Almost a third of nurses according to the survey plan to leave their current employer within two years, and more than 10 per cent plan to leave nursing altogether – and 29 per cent say they would leave nursing if they could.

Work permit data show that permits for the health and medical services industry overall, increased from 1,774 in 1995 to 26,568 in 2004 (Salt 2007). Following the 2004 enlargement of the European Union, residents from the ‘Accession 8’ (A8) countries were allowed to work in the UK, and this new source of labour fed significantly into low-skilled jobs in the social care sector – almost 24,000 by early 2009 (Cangiano, Shutes, Spencer & Leeson 2009).

According to recent Labour Force Survey data, 135,000 migrant care workers were working in the United Kingdom at the end of 2008. Migrant workers thus accounted for 18 per cent of *all* care workers compared with 13 per cent of the total labour force, and this was an increase from 8 per cent of the care workforce in 1998. Migrant workers comprise a larger proportion

(23 per cent) of the nursing workforce, and this is again an increase on the 1998 figure (13 per cent). According to Cangiano, Shutes, Spencer & Leeson (2009), migrant nurses account for over one third (35 per cent) of the nursing workforce in older adult care. Almost half of the current stock of migrant care workers and nurses entered the United Kingdom over the previous 10 years. It is interesting to note that arrivals of migrant nurses outnumbered the arrivals of care workers at the end of the 1990s and the beginning of 2000s, but this has reversed in more recent years.

Further evidence of the growth of the migrant care workforce in recent years and its contribution to the overall care workforce is provided by data from the Labour Force Surveys (Cangiano, Shutes, Spencer & Leeson 2009). With regard to care workers, both non-migrant and migrant groups contributed to the significant expansion of the workforce since the late 1990s – both the growth of the overall workforce and the contribution of migrant care workers to this growth are quite striking between 2003 and 2008, when almost half of the additional 155,000 workers who joined the social care workforce were foreign-born. The migrant workforce more than doubled in the period 1998-2008.

In addition, while the total nursing workforce declined by about 20,000 towards the end of the 1990s, the migrant nursing workforce increased by 15,000 corresponding to a 23 per cent increase. The massive recruitment of overseas trained nurses and investment in the training of new non-migrant workers resulted in an increase in the size of the nursing workforce by almost 60,000 and most of this increase comprised migrants (a growth rate of 54 per cent).

The areas of origin of migrant carers have changed over time (Cangiano, Shutes, Spencer & Leeson 2009), and while some countries of origin are the same for the nursing and care workforce (e.g. Philippines, India, several African countries and, in the past, Ireland, and Jamaica) their relative importance has changed.

As far as recent flows of migrant care workers are concerned, Eastern Europe – Poland in particular – and sub-Saharan Africa have been the major areas of origin. In recent years, migrants from Zimbabwe, Poland and Nigeria have taken over from those from Ireland, Germany and Jamaica as the three main groups. Following the enlargement of the European Union in 2004, Poland became the main source country of migrant carers. The Philippines and India are also among the main source countries, but to a lesser degree than is the case for migrant nurses. The five main source countries account for half of the inflow of recent migrant carers.

With regard to country of origin of migrant nurses, more than half of recent migrant nurses have come from either the Philippines or India, which is a result of the active recruitment policies based on bilateral agreements with these countries – this is illustrated in the case study components below.

Another cause for concern and part of the risk management strategy is the regional distribution of migrant carers. The distribution across the United Kingdom is markedly uneven, with a high concentration in the south of the country (Cangiano, Shutes, Spencer & Leeson 2009). London and the South East host together about half of the migrant care workforce in the country. London is easily the main destination among migrant nurses, while a comparatively larger share of migrant carers work in the South East. The South West, the North West and the West Midlands are also important destinations. This uneven regional

distribution masks more marked differences in terms of the contribution of migrants to the local care workforce. The proportion of migrant care workers is highest in London – 60 per cent of both the nursing and the social care workforce. Migrants also account for a high share of the social care workforce in the South East (25 per cent). In other regions of the country, however, migrant carers comprise a smaller proportion of the care workforce than the national average, ranging from 14 per cent in the West Midlands to 7 per cent in Wales. There is a positive correlation between the concentration of older people and the employment of migrants in social care.

Clearly then, the statistics for the end of the 20<sup>th</sup> and beginning of the 21<sup>st</sup> centuries reveal – as well as interesting changes in the composition by country of migrant carers and the growth in their numbers – the (growing) importance of migrants in the health and social care workforce in the United Kingdom at a time when concerns about the ageing of the population and the difficulties in attracting qualified and committed carers into this sector were a key issue across Europe (Leeson 2005).

A number of concerns thus existed. One was the sustainability of the models for the provision of care for older people across Europe, with an increasing reliance on migrant carers, both formal and informal (Cangiano, Shutes, Spencer & Leeson 2009; Lamura 2003; Leeson & Harper 2004). A second concern was the adequacy of the infrastructures to accommodate the needs of migrant carers and thereby ensure a satisfactory level of quality of care (Leeson & Harper 2004).

Why have employers in this sector looked increasingly to migrants?

Many vacancies in social care are termed ‘hard to fill’, and this is generally attributed to skills gaps (a shortage of suitably qualified candidates), rather than to an overall shortage of applicants (Learning and Skills Council, 2006). High levels of turnover in the social care workforce add to the challenge for employers. Recent survey data reveal some interesting aspects of this situation (Cangiano, Shutes, Spencer & Leeson 2009; Lamura 2003; Leeson & Harper 2004).

So, for example, a high proportion of the surveyed care-home employers state it is difficult to find non-migrant workers – 58 per cent in relation to nurses and just under 50 per cent in relation to carers. The demand for migrant care workers is related to the difficulty of recruiting non-migrant nurses and carers. Most employers relate the difficulty to recruit/employ the non-migrant carers to poor working conditions, lack of career opportunities, skills’ mismatch and scarce motivation. 87 per cent agreed that non-migrant workers are able to earn more in other jobs and 74 per cent that this group demands higher wages than those available in the social care sector. The other main causes of difficulty to recruit non-migrant carers stated by employers surveyed are an unwillingness to do shift work (72 per cent), the high probability that they leave the job (67 per cent), and the lack of the right work experience (66 per cent).

Employers in the care sector acknowledge that migrant workers are beneficial for their businesses in a number of ways. 82 per cent of those employing either migrant nurses or carers agreed that migrants are willing to work all shifts, which is important in this sector. The majority also felt that migrants are willing to learn new skills (75 per cent), have a good work ethic (71 per cent) and are respectful towards older clients (68 per cent). For 66 per

cent of the surveyed employers, the main disadvantage associated with employing migrant carers is poor language skills. With regard to the quality of care, more than 60 per cent of the surveyed employers felt that employing migrant workers had not changed the quality of care provided, and 31 per cent in fact felt that the quality of care provided had improved.

By limiting the mobility of migrant workers within the care sector and the wider labour market, the status of work permit holders served to provide retainable care workers for residential and nursing homes. On the other hand, the irregularity of status of some migrant carers (for example, those who had overstayed student or tourist visas or asylum seekers not entitled to work) also “encouraged” them to stay in care jobs despite the poor terms and conditions of their work. The rights of nationals of European Member to work in the United Kingdom meant they were able to ‘move on’ to other jobs in the care sector, unlike other migrant workers.

## Part 3 - Lessons learned and guidance

In this final section, we choose to illustrate lessons learned by way of concerns expressed by various component cases (Leeson & Harper 2004).

So what are the concerns relating to migrant carers? What are the barriers to optimal and sustainable recruitment and retention of migrant carers in an ageing population?

From the component cases, we are able to outline the concerns which are both component specific and cross-cutting, and from a future scenario, we are able to outline the empirical sustainability of the recruitment and retention of migrant carers in an ageing population.

### The component cases

The component cases cover the primary, secondary and long-term care sectors in the United Kingdom and major organisations and training institutions relevant to the field. Both private and public providers are included.

The material reveals a consistency in respect of barriers and concerns across the different types of component cases. The cases, which provide the basis for the overview in this Part of the report, are a care agency, a professional organisation, an NHS trust, a residential care home, and training institutions.

The cases provide a diversity of organisational frameworks in the context of the provision of care for older people and address directly or indirectly issues relating to migrant carers within these frameworks.

There are two broad areas of concern, where lessons can be learned. The first area is **attitudes and skills** and the second area is **recruitment and retention**.

**Attitudes and skills** concerns relate to a number of issues. The first of these is clear staff and client reactions to foreign workers. Some of this attitudinal opposition to migrant carers is a result of stereotypical perceptions. Some is related **communication skills**. This relates to both day-to-day communication but also to care communication skills required for the specific job. Related to this is the concern of larger nationality groups tending **not to integrate** to the same extent, and **speaking their native language**.

Secondly, there is the **culture of care** of migrant workers. In the United Kingdom, the culture of care is proactive while many migrant carers originate from a reactive culture of care, which can then be interpreted in the field as a lack of initiative.

Thirdly, the levels of **training** are a concern.

Strategies to address these issues are:

- TOPSS training programme (Training organisation for personal social services) has been compulsory for all care staff and support workers (irrespective of nationality) and is part of the induction process for foreign workers. In addition, the central feature of the National Vocational

Qualifications (NVQ) programme is the National Occupational Standards (NOS), which are statements of performance standards describing the competences expected in particular occupations. This involves staff observation, which should reveal shortfalls in competences among migrant carers. Specialised and extra training can then be offered to staff not performing to the required competence levels of the agency and the profession. An integral part of the National Care Standards is an individual appraisal, which should pick up on shortfalls;

- not being able to understand regional accents leads to a loss of confidence and it is a failing of the language courses offered that the language is presented with no context and with no adaptation to different cultural and professional needs. Culturally contextualised English is necessary. Culturally-based misunderstandings can lead to incorrect perceptions about levels of co-operation, initiative and intelligence. What is perceived as aggressive, passive or assertive behaviour is very much culturally determined;
- adverse publicity: claims that there are problems associated with recruiting from overseas are often widely publicised in the media, and this may contribute to negative attitudes towards nurses and other healthcare professionals from overseas. Overseas students need to be supported to assure communication skills that will avoid such negative attitudes;
- orientation programmes for overseas nurses: the issues outlined can be addressed by good quality orientation programmes embracing language, communication and cultural issues. Programmes should aim to build on the existing knowledge and experience of overseas nurses, empower them, support them within the clinical areas and promote anti-discriminatory practices;
- teaching and learning strategies: group work increases the autonomy of students and improves cross-cultural communication. Teaching in which the authority of the teacher is gradually reduced allows students to develop their skills through practice and use rather than *being taught*;
- English for Specific Purposes programme design: the promotion of three abilities should underpin the design. These are the ability to use health care jargon, the ability to use a more generalized set of skills, and the ability to use the language of everyday informality.

**Recruitment and retention** concerns relate to the changing nature of the skills needs in the United Kingdom. This needs to be addressed by developing new international recruitment and retention strategies, which would aim to:

- focus resources in international recruitment on areas of the greatest benefit to older people in need of care – either in their own home or in institutional settings;

- ensure that efforts in international recruitment and retention are managed effectively and efficiently;
- ensure a co-ordinated approach balancing flexibility and cost-effective frameworks for recruitment and adaptation;
- support other recruitment initiatives that demonstrate an integrated approach to staffing;
- analyse the scope for international recruitment of allied health professionals.

The key objectives of such new recruitment and retention strategies would be to:

- ensure integrated workforce planning in relation to international recruitment;
- optimise the recruitment and retention of international staff;
- develop the skills of the internationally recruited workforce and
- ensure frameworks to support international staff.

### **The future scenario**

In this section, we consider the absolute sustainability of migration as a policy response to the provision of a health and social care workforce in the United Kingdom.

Recent research (Cangiano, Shutes, Spencer & Leeson 2009) has projected the future trends in demand for migrant and non-migrant care workers and nurses working with older people in the United Kingdom. It is cell-based and consists of three components. The first estimates the base year numbers of carers (care workers and nurses) working with older people – based on a combination of different data sources – and the respective dependency care ratios (the ratios of care workers and nurses caring for older people to the number of people aged 65 years and over); the second uses the official demographic projections (by age group and gender) of the older population (GAD 2007) to estimate the number of carers required for maintaining constant dependency care ratios; the third estimates the numbers of migrant and non-migrant carers required on the basis of low, medium and high assumptions in relation to the contribution of the migrant workforce. The three scenarios represent a form of sensitivity analysis of the demand for migrant and non-migrant carers to work with older people in the United Kingdom. Assumptions in relation to the number or proportion of migrant carers are as follows:

*Low scenario:* the base year *number of migrant carers* is kept constant throughout the projection period.

*Medium scenario:* the base year *percentage of migrant carers* is kept constant throughout the projection period.

*High scenario:* the base year *number of non-migrant carers* is kept constant throughout the projection period.

Essentially, the low scenario assumes that the future additional demand for care work has to be met entirely by workers born in the United Kingdom; the high scenario that it has to be met entirely by foreign born workers; and the medium scenario that foreign born workers

have to contribute to the expansion of the care workforce to the same extent that they are contributing at the beginning of the projection period.

It is estimated that 642,000 care workers and 60,000 nurses were working in the care of older people in the United Kingdom in 2006. The dependency care ratios in 2006 were thus 0.0663 for care workers (i.e. 1 care worker per 15.1 older people) and 0.0062 for nurses (i.e. 1 nurse per 160.7 older people). It is further estimated that around 122,000 care workers (19 per cent of the workforce) and 21,000 nurses (35 per cent of the workforce) were born outside the United Kingdom at the beginning of the projection period.

According to the projected population development for the older population aged 65 years and over and with constant care ratios as estimated in the base year, the total number of care workers (individuals) involved in older adult care is projected to increase from 642,000 in 2006 to 1,025,000 in 2030, and the total number of nurses working with older people from 60,000 to 96,000 over the same period. These growth figures are in their own right significant and demand that the policy and structural framework surrounding the recruitment and retention of carers of older people be addressed. In addition to this overall concern, the reliance on foreign born workers and the prospect of that reliance potentially increasing makes the need to address the sustainability of the workforce caring for older people even more acute. The projections reveal that varying degrees of pressure on the demand for migrant care workers are possible. If the percentage of migrant carers looking after older people in the UK has to remain constant, the number of migrant carers is projected to increase from 122,000 in 2006 to 195,000 in 2030 – an average annual growth of around 3,000 or 2.5 per cent. Although significant, the (net) number of new migrants joining the care workforce under this scenario would be smaller than the expansion of the foreign born care workforce observed over the past decade. This would represent a slowdown in the short term compared with the unprecedented levels of care worker migration of the last decade, but still a considerable expansion of the foreign born workforce over a 25-year period.

If, however, the future additional demand for care work has to be met entirely by migrant workers (high scenario), the number of foreign born care workers is projected to increase to 505,000 – an average annual growth of 16,000 or 13.1 per cent, so at least double that of the past decade. Under this extreme assumption one in two care workers would be foreign born at the end of the projection period. This is similar to the current situation in London (Cangiano, Shutes, Spencer & Leeson 2009). The demand for foreign born nurses under the three scenarios is more modest in terms of numbers but not in terms of percentage growth rates – just above 500 a year, corresponding to an average annual increase of 2.5 per cent under the medium scenario, and around 1,500 a year (or an average annual increase of 7.1 per cent) under the high scenario.

No element of prediction is intended in these projections. However, the scenarios do reveal that future demand is sensitive to the assumptions about the relative prominence of home born and foreign born within the composition of the workforce, and they do have clear policy implications. While not predictive as such, the scenarios raise the important issue of the sustainability of the provision of care for older people **without** designated policy input either with regard to migrant carers or with regard to the recruitment of home carers.

The scenario growth figures in the numbers of migrant carers required to keep pace with the demographic development stand in sharp contrast to the most recent admissions figures from the Nursing and Midwifery Council presented earlier in the report.

Whatever the policy focus, there is likely to be a short fall in the manpower available in the care sector for older people, and this in turn will place pressure on recruitment and levels of qualification and ultimately the quality of care provided.

Absolute sustainability is one side of the issue – are the numbers desirable, manageable, even doable?

The other side of the issue – as addressed in the component cases – is whether the infrastructures in place to accommodate an eventual influx of relatively large numbers of migrant carers (as part of a conscious policy response or an unintentional labour force development) are adequate.

The evidence would suggest that absolute sustainability is challenging in its own right – both the question of numbers and the question of maintaining standards of care under such absolute pressures on the workforce. The component cases evidence would also suggest that there are serious and significant challenges to the infrastructures, not least communication skills, culture of care, attitudes, training and values.

While acknowledging that it may not be desirable in the long term for migrant workers to be recruited into the care sector for older people, further restricting the entry channel for senior care workers is likely to exacerbate the difficulty employers are experiencing currently – as evidenced in this report.

Migrants recruited on the local labour market are still providing a significant workforce in this care sector. The future scenarios presented here show, however, that the ageing population will require a significantly larger care workforce. Even if the percentage of migrants was to remain constant, a greater number of migrant carers would be needed. There can be no confidence that wage levels in the sector will rise sufficiently to meet all of the growth in demand from within the United Kingdom. The contribution within the care workforce of those migrants who enter for other purposes – as spouses, refugees, students, domestic workers, working holiday makers or on ancestral visas – needs to be recognised. A system to monitor labour shortages in care work, and the contribution which different categories of migrants are making in meeting those shortages, is needed. If in the long term there is an unmet demand for less skilled care workers government needs to consider allowing direct entry for migrants to take up these jobs. Temporary staffing is not a desirable option in this sector. It would run counter to the need for continuity in care, older people and employers being constantly faced with new staff adapting to their roles in a context where understanding cultural nuances and particularities of language can take time to acquire, and relationships with older people time to develop.

Government needs to ensure that there are structures in place that enable migration policy to take account of staffing needs in the care sector and of government objectives in relation to up-skilling the workforce, continuity of care and protection of vulnerable workers.

Consideration needs to be given to fostering the integration of migrant carers not only within the labour market but within the wider community. It is not in the interests of older people, nor of employers, if carers face unnecessary barriers to integration and are discouraged or prevented from remaining in the United Kingdom. Furthermore, if the Government proceeds with its intention to ‘speed up the journey to British citizenship and permanent residence’ only for those who demonstrate ‘active citizenship’ through voluntary work in the community, it should recognise the significant contribution that migrant care workers are already making and that it would neither be appropriate nor feasible in practice for many to make a further voluntary contribution given the long hours and shifts that they are already working.

Language and the colloquialisms and nuances of personal communication, coupled with understanding of cultural norms relating to personal care, can be a significant challenge for migrant workers. Notwithstanding examples of good practice, the language and induction training currently available would seem from the evidence to be insufficient. Government and skills agencies need to ensure that such provision is made and guidance material available.

Statutory and independent sector organisations engaged in older adult care equally need to take account of the significant number of migrant carers in the sector and of the issues which this raises. There is a broader need to ensure that care staff members have access to accurate information on the conditions attached to their immigration status, their rights at work and where they can access further information and support. In this trades unions and professional associations in the care sector have a key role to play. There is also a need for government to review certain restrictions on those rights.

There is also a need for the appropriate authorities to respond to the hostility some older people and professionals are expressing towards migrant carers. Managers and care staff should have appropriate training on equal opportunities in employment and service provision; and older people and their families should have guidance on their responsibilities as employers in home care. Those care users and families who are not initially comfortable with care provision by migrant workers also need to be helped to understand the essential contribution which migrants now make to care services and that staff, like older people, have a right to be in an environment that respects their dignity and self-worth.

The contribution which care workers are making to the care of older people is invisible to the majority of the public who are not in regular contact with the care system. Within a negative political climate, it is easy for the public to overlook the particular contribution which migrant care workers are making, doing a demanding job for low financial reward. As debates on reform of the care system are taken forward, the essential contribution of the care workforce as a whole, and of migrant carers among them, in providing quality care for older people, should be given greater public recognition and – along with the focus on the rights of older people – lie at the heart of proposals for reform.

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