Moved to care: the impact of migration on the adult social care workforce

Authors: Ben Franklin and Cesira Urzi Brancati
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Executive Summary

What does this report seek to address?

This report outlines key findings from new research, conducted by the International Longevity Centre UK and Independent Age, into the importance of migration to the adult social care workforce in England. Despite a growing body of literature and speculation about the future of adult social care on the one hand, and the socioeconomic implications of migration on the other, there has been little informed discussion about the role of migrants in the delivery of care and how this might evolve over future decades.

With the older population set to grow significantly faster than the working age population, there is a big question about whether we will be able to look after the swelling numbers of older people in need of care. The age group that is likely to grow the fastest over the coming decades is the ‘oldest old’, with the number of people over 80 expected to double in size from around 2.7 million today to over five million by 2037. But despite evidence of rising care needs, the adult social care sector is facing significant challenges in recruiting, paying for and retaining its staff. At the same time, the government is seeking to reduce net migration to the tens of thousands, which in principle means putting severe restrictions on low-skilled non-EU migration and potentially involves a renegotiation of its relationship with the EU. This report therefore focuses its attention on four critical areas:

1. The current role of migrants within the care workforce.
2. The reasons why migrant care workers are in demand.
3. The potential impact of public policy on the ability of the care workforce to meet demand over the long term.
4. Recommendations about what different stakeholders can do to ensure the workforce is able to meet future demand.

Approximately 1.45 million people work in the adult social care sector in England*

The care funding squeeze

Social care is under financial pressure due to a long-term lack of funding

- While health spending increased from £97.5 billion in 2010-11 to £116.4 billion in 2015-16 (an increase of 19.3%), over the same period, social care funding has decreased from £14.9 billion to £13.3 billion (a reduction of 10.7%).
- With further spending cuts expected, and the introduction of a new National Living Wage imminent, the sector is likely to be under even more financial pressure over this parliament.

The current role of migrants within the care workforce

Migrants and particularly non-EU migrants play a big role in the care workforce

- Nearly 1 in every 5 care workers was born outside of the UK – equating to approximately 266,000 people.
- Non-EU migrants account for the greatest proportion of migrants working in care – some 191,000 people – approximately 1 in every 7 care workers.
- About 14% of the non-EU migrants working in adult social care today arrived in the UK between 2011 and 2015. During the same five years, 40% of the EU migrants working in adult social care today arrived in the UK.

Among foreign born workers, 72% were born outside of the EU.

The remaining 28% were born in the EU.
Among migrants who arrived in the UK over the last eight years (between 2007 and 2014), the top five countries of birth are: India (13%), Poland (12%), Philippines (11%), Romania (11%), and Nigeria (7%).

Nearly 1 in 3 of all care workers employed in high-skilled professional roles, such as registered nurses and occupational therapists, are non-EU migrants.

Among migrant care workers, over 150,000 are employed in care homes, while 81,000 work in adult domiciliary care (home care) and an additional 35,000 work in other care workforce roles such as adult community care services.

London and the South East are particularly reliant on migrant care workers

London has a very high concentration of migrant workers, with nearly 3 in 5 of its care workforce born abroad, and approximately 9 in 10 of its migrant care workers coming from outside of Europe.

The South East also has a relatively high proportion of migrant workers – with 1 in 4 care workers born abroad.

Other regions rely far less heavily on migrant workers. In the North East, for example, over 95% of care workers are UK born.

Migrants typically work in hands-on care roles

Among the 266,000 migrants working in the sector, the vast majority are in direct care roles (200,000), and of those migrants working in direct care 150,000 were born outside of Europe.
The reasons why migrant care workers are in demand

The care sector finds it tough to recruit and retain staff

- The care sector’s overall vacancy rate of 4.8% is significantly higher than the vacancy rate for the UK’s labour force as a whole – 2.6%. With over 70,000 unfilled vacancies in the adult social care sector at the last count, the care sector is significantly less able to fill new job openings than the rest of the economy.

- The Care Quality Commission found in 2013/14 that 1 in 5 nursing homes did not have enough staff on duty to ensure residents received good, safe care.

- The care sector also finds it particularly difficult to retain its staff – with a turnover rate of 23.9%. This means that around 1 in 4 employees will leave their employer during the year.

The care workforce is relatively old

- Approximately 1 in 10 care workers are aged 60 or over and therefore might expect to retire within the next few years.

- A large proportion of employees only start working in the sector late on in their careers. Indeed 1 in 4 of the UK born workforce, and about 1 in 5 migrants, start work in the sector aged 44 or over.

Working in care is unattractive for many due to uncertain hours, low pay and stressful working conditions

- About half the workers in the sector are full time (vs. 70% in the general workforce), and about 85% are employed permanently (vs. 93% in the general workforce). While some prefer the flexibility of part-time working, others do not.

- Average pay for frontline care roles in 2013-14 was estimated to be around £7.20 per hour, comparing unfavourably to a living wage at that time of £7.45 outside London and £8.55 in London.

- Moreover, approximately 1 in 10 care jobs actually pay below the minimum wage as a result of employers only paying for contact hours and not travel time between visits.

- A previous survey undertaken by Skills for Care found that many social care and support staff have faced verbal (93%) and physical (53%) abuse.
Migrant care workers are typically younger and relatively better skilled

- The median age of workers in the adult social care sector is 44 years. The migrant care workforce is younger than the UK born care workforce. The median age for EU migrants is 37 and for non-EU migrants it is 42.
- After accounting for factors such as gender, age and years of experience in the sector, migrant workers – and particularly non-European migrant workers – are significantly more likely to be high skilled (have a qualification equivalent to level 4 or above) compared to UK born workers.

Migration policy is increasingly restrictive to non-EU migrant workers

- Tier 3, through which low-skilled non-EU workers would be able to enter the UK labour force, has never been opened. This is limiting the extent to which non-EU migrants can enter the social care sector.
- Non-EU migrants are currently judged on a points-based system, with Tiers 1 and 2 (for high-skilled non-EU migrants) now subject to an annual cap of 21,700 people.
- Care workers do not appear on the Migration Advisory Committee’s Tier 2 Shortage Occupation List.
- From April 2016, non-EU migrants who entered the UK on a Tier 2 visa and have spent more than five years working in the UK will be required to earn £35,000 per year or may have to leave.
- We have concerns that some high-skilled adult social care workers, currently working in England, may have to leave as a direct result of the new earnings threshold for migrants who entered via the Tier 2 route.

The potential long-term impact of public policy on the care workforce

- Based on plausible assumptions around future trends, we project that by 2037, if working in care becomes increasingly unattractive and net migration is comparatively low, the workforce could have over one million fewer care workers relative to demand than is the case today.
- On the same projection, we estimate that there could be a workforce gap of 200,000 by the end of this parliament, which equates to 14% of today’s care workforce.
• Public policy scenarios that strive to meet future adult social care workforce needs through greater migration only or just by increasing the attractiveness of the sector, are unlikely to succeed – resulting in large workforce gaps.

The least risky approach we modelled would be to raise both the attractiveness of working in care for UK born workers and encourage migrant labour to meet future social care workforce needs.

• In our most optimistic scenario – where the sector becomes increasingly attractive to the UK born workforce and net migration is relatively high – by 2037, the care workforce would have 353,000 fewer care workers relative to demand than is the case today.

• Clearly this is still a significant gap, but it is much smaller than if the workforce was to become increasingly unattractive to the UK-born population and restrictive to migrant labour.

• The scenarios help to illustrate that it is only through substantive policy change and a dramatic shift in the attractiveness of the care sector to UK born workers that we will be able to generate sufficient workers to meet future demand without an increasing reliance on unpaid carers.

• In order to close the workforce gap over the entire period, the proportion of working age people in England, working in the adult social care sector, needs to rise from around 4% today, to around 6% by 2037 – which contrasts with the rise from 4% to 5% assumed in our most optimistic scenario.

• This sort of shift is not impossible, but it is likely to depend on the adult social care sector being able to compete with, and attract workers from other large sectors of the economy.
Policy recommendations

The short term: plugging workforce gaps will require retaining and attracting migrant labour.

- Skilled care worker roles, including senior care worker, should be included in the current Migration Advisory Committee’s Tier 2 Shortage Occupation List.

- Non-EU migrant care workers who have entered the care sector through Tier 2 should be exempt from the £35,000 income threshold. The alternative approach is to lower the income threshold for specific jobs in the sector, but this may still result in some workers falling below the threshold, despite being high skilled and providing socially useful roles.

- Because the Shortage List only includes skilled migrant labour, there is no equivalent path for low-skilled non-EU migrant labour despite the reliance of the care sector on it. This report recommends that Tier 3, which is for low-skilled workers filling temporary labour shortages, be opened up for care workers in order to help the sector meet immediate staffing needs.

The medium to longer term: attracting more UK born workers into the sector must be a priority

- The government and other stakeholders need to find ways to make the care sector more attractive for groups who are currently under-represented in the workforce. This report calls for:
  - **Step up to adult social care:** This would be an intensive Postgraduate Diploma to equip the future generation of adult social care workers with the right mix of knowledge and practical skills to drive the sector forward.
  - **Care-prentices:** The importance of stimulating longer working lives is being increasingly emphasised in policy circles. Offering care-prentices – structured on the job training with formal mentoring and support for those over 50 – could be one way to entice older workers into the sector.
  - **A national campaign to attract more male care workers:** Government and industry could work together to deliver a joint campaign calling out for more male care workers, supported by examples of men who are currently playing important and fulfilling roles in the sector.
The need to improve funding arrangements for adult social care

- Underfunding of adult social care contributes to many of the workforce challenges highlighted in this report. It limits the resources available for providers to invest in their staff and recruitment.

- We agree with the principle of a single ring-fenced budget for health and social care to support integration of services and reduce the current disparity between health and care spending. However, integration must not result in both health and social care fighting over one increasingly limited pot.

- In this context, we argue for the creation of an independent committee to continually monitor current and projected health and social care needs at the national level and to recommend future funding levels. The government would have ultimate say as to whether or not it takes forward those recommendations, but establishing such a committee would provide some much needed transparency to this highly complicated area.

The need for better support for unpaid carers

- Future care workforce challenges may mean that there will be a continued or potentially greater reliance on unpaid carers to support the needs of older people.

- While it should not be assumed that unpaid care is available to substitute for professional care, there is a clear case for providing better support for unpaid carers to alleviate the financial, mental and physical costs that they can face.
This report aims to understand the current and future role of migrants within the adult social care workforce. In this way, the report contributes to current debates about the effects of migration on UK society by honing in on the importance of migration to a single, significant sector of the economy, adult social care.

Much has been written and said about the wider effects of migration on the labour market, public services and social cohesion, and this has been gathering steam in light of recent events in Calais and the Mediterranean. Our view is that debates about migration should be set against the broader long-term, strategic context of population ageing – a seismic shift which is reshaping societies in developed and developing countries. Population ageing is characterised by an increasingly large older age population and a slowdown (or fall in some countries) in the working age population. This has implications for economic output and tax revenues as growth in the supply of workers to produce goods and services slows, as well as for government expenditure, as spending on health and social care rises to meet the needs of older people.

Migration can help to offset some of these effects by boosting the supply of available workers – though it is no silver bullet. For instance, the independent forecasting agency, the Office for Budget Responsibility (OBR), forecasts GDP growth to be 2.5% per annum up to 2025 if we have high migration, by comparison to 2.3% per annum if we have low migration1. In the short term, such a difference does not look particularly dramatic, but sustained over many years, higher rates of growth can have a significant impact on the overall level of economic output and ultimately the affordability of government debt. Indeed, the OBR has forecast that by 2050, total government debt as a proportion of GDP would be 76% if we have low migration over the intervening years, by comparison with 56% if we have high migration.

In many ways, the health and social care sectors are at the frontline of this debate. Significant numbers of employers already rely heavily on migrants to fill nursing jobs, hands-on care roles and a multitude of other occupations. Their services are under increasing pressure due to population ageing and this is set to intensify. The number of people in England aged over 65 is expected to increase from around 9.7 million today to around 15 million by the late 2030s (an increase of over 50%). The age group that is likely to grow the fastest over this period is the ‘oldest old’, with the number of people over 80 anticipated to double in size from around 2.7 million today to over five million by 20372. With the ‘oldest old’ being the most likely to need health and social care, the sector’s workforce will need to expand significantly in order to meet this demand.
In this context, this report centres on the role of migrants within the adult social care workforce in England. There are approximately 1.45 million people employed in the English adult social care sector of which 266,000 people (one in five care workers) were born outside of the UK. Of those migrants working in the sector, approximately three in four come from outside the EU.

Some parts of the social care sector and some regions are particularly reliant on migrant workers:

- **London and the South East:** 6 in 10 care workers in London and 1 in 4 in the South East of England were born outside of the UK.
- Among all migrants working in the sector, the vast majority work in direct care roles (200,000), and of those migrants working in direct care, **150,000 were born outside of Europe**.
- Nearly 1 in 3 of all care workers employed in high-skilled professional roles, such as registered nurses and occupational therapists, are non-EU migrants.
- Among migrant care workers, the majority (150,000) are employed in care homes.

In addition to supporting these parts of the care sector, migrant workers are also generally younger than their British born counterparts and hold higher qualifications for their respective job roles. Evidence suggests that employers within the sector often perceive migrants to be hard-working and relatively cheap given their acquired skill sets, while migrants are often drawn to the sector as a means of gaining work experience in the UK.
With demand for adult social care likely to rise, there is a big question about where the necessary workers are going to come from. Growth in the so called “working age population” is going to slow, which will make it harder to recruit from traditional sources – i.e. women aged between 16-64 who make up roughly 8 out of 10 care workers. With care work continuing to be perceived as low paid feminine work, attracting people from non-traditional sources is likely to prove difficult.

But we may not be able to rely on migrant workers to plug the gap. Despite migration accounting for a significant proportion of the workforce today, current and anticipated migration policy may make it harder to recruit from abroad to help fill workforce gaps over the coming years. Migration policy has become increasingly restrictive to non-EU migrants who make up the largest proportion of migrants working in the adult social care sector.
Not only will anticipated policy make it almost impossible for care providers to recruit from non-EU countries, it may also make it difficult for some of the non-EU born workers, already working in the UK, to remain working here. While some care providers may be able to recruit from the EU in the short term to fill any workforce gaps, there is significant uncertainty about how the UK’s ongoing negotiations and eventual referendum on EU membership will affect EU migration over the medium to longer term.

To better understand how different migration and adult social care policies might affect the workforce over the long run, this report develops some simple scenarios based on realistic assumptions to outline alternative possible future situations. Given the pressures of an ageing population, and a slow-down in the growth of the working age population, we show how public policy must in fact aim to encourage both more UK born residents and more migrants into the care sector. Anything less than this will result in a sector that fails to meet future demand for care. Indeed, in a modelled scenario that best resembles the current direction of travel – an increasingly unattractive sector coupled with reduced migration – we could have at least one million fewer adult social care workers than we will need by 2037 to keep up with demand. To put this figure into perspective, it equates to nearly 70% of the total adult social care workforce today.

Migration is clearly a politically sensitive topic, but we must be pragmatic about how we are going to fill some of the lower-skilled, lower-wage, but socially important jobs, which are often neglected in current debates. Therefore, we conclude our report with some recommendations about how we might build this sort of requirement into the current migration policy framework, with reference to examples from other countries.
Approach and methods used in this report

To understand the current and future role of migrants in the care sector, this report focuses on two key questions:

1. **To what extent is the adult social care workforce currently dependent on migrant workers and in what ways?**

2. **How might current and future public policies related to migration and adult social care impact on the ability of the workforce to deliver care to an ageing population?**

To answer these critical questions this report will explore the following:

**Chapter 1** outlines the most recent policy developments in terms of care funding, the adult social care workforce and migration.

**Chapter 2** provides new insights on the composition and characteristics of migrants in the adult social care workforce in England through analysis of the largest dataset available.

**Chapter 3** examines the reasons why employers within the care sector choose to take on migrant workers in the first place and why migrants want to work in the sector. It also includes some case studies to show the viewpoints of migrants working in the sector.

**Chapter 4** uses scenario analysis to understand the potential long run implications of public policy on the size of the care workforce and its consequent ability to meet rising demand for care.

**Chapter 5** explores what other EU countries are doing with regard to encouraging migration into the adult social care sector and whether the UK could learn any lessons from them.

**Chapter 6** concludes the report by bringing together the short and long run implications of public policy on the care sector and provides some migration-related policy recommendations.

**How does this report analyse the current composition of the workforce?**

The first challenge to address in this report is what actually constitutes the adult social care workforce and which regions of the UK we should look at. Because there is no aggregate data on the care workforce at the UK level, our analysis refers to the adult social care workforce in England as defined by the National Minimum Data Set on Social Care (NMDS-SC) for England. This is a vast data source that contains detailed statistics on the state, size and structure of the workforce, of which there is no comparable dataset for other UK nations.
The total adult social care workforce of England encompasses a broad array of care-related occupations which are listed in the appendix.

For the remainder of this report, when we refer to the adult social care workforce, or care workers, we are referring to the people working among this diverse array of paid occupations.

**How does this report assess the long-run implications of government policy?**

We use scenario planning to understand what different futures for social care might hold. Scenario planning is a technique used for long-term strategic analysis and planning. Scenarios are often set out in narrative form to describe how the future might look given certain assumptions around future trends and events. The approach is described in more detail in chapter 4.

**Is this report concerned with England or the UK?**

While this report is focused on the future of the adult social care workforce in England, our analysis of migration policy is focused at the UK level. This is because, while adult social care policy is different for different UK regions, migration policy is set at the national level. As a result, our recommendations are largely UK centred with regards to migration policy and England centred with regards to the future of adult social care.

**How did we find illustrative case studies of migrants working in the sector?**

To highlight some real-life examples of migrants working in the adult social care sector, we undertook a number of interviews with staff employed at four organisations, two residential care providers and two private homecare agencies.

From these interviews we were able to draw together a selection of case studies, which help to illuminate some of the challenges and opportunities facing migrants in the sector. While our case studies do not reflect the collective voice of the migrant adult social care workforce, they do represent compelling stories which help bring to life the representative data used in this report.
Policy context: The current “squeeze” in adult social care and a changing climate for migration

Key points

• Long-term underfunding along with increasing demand for care is limiting the ability of the sector to deliver care for those in need.

• Political short-termism, along with the introduction of the new National Living Wage, could create further challenges for the sector.

• Non-EU migrants are currently judged on a points-based system, with Tiers 1 and 2 now subject to an annual cap of 21,700 people.3

• Tier 3, through which non-EU low-skilled workers are able to enter the UK labour force, is currently closed – indeed it has never been opened. This limits the extent to which non-EU migrants can enter the social care sector.

• Jobs in large parts of the adult social care sector are currently not included in the shortage list for non-EU migrants.

• In October 2015, the government asked the independent Migration Advisory Committee to review whether nursing roles should be placed on a shortage list for non-EU migrants.

• From April 2016, high-skilled non-EU migrants who have spent more than five years working in the UK, will be required to earn £35,000 per year or else may have to leave.

• Finally, the government is likely to hold a referendum on the UK’s membership of the EU and to try and impose restrictions on in-work benefits for EU migrants. This could have a significant impact on the current and future adult social care workforce.
About this chapter

This chapter sets out the current policy background both in terms of the current crisis facing adult social care and the current state of migration policy in the UK. Both policy areas are rapidly evolving, sometimes on a daily basis, so what follows represents the most up-to-date account at the time of writing.

Current “squeeze” in adult social care

“We are facing a great adult social care squeeze, with need for care growing while public funding is falling”

Margaret Hodge, Chair of Public Accounts Committee, 2014

The adult social care sector is facing a number of challenges. While some are the result of relatively recent political and economic developments, many are symptoms of deep underlying structural and demographic issues facing the UK.

In June 2015, Ray James, President of the Association of Directors of Adult Social Services warned that “what is at stake is the continuing capacity of adult social care to sustain services to those in greatest need. In virtually all our authorities, the number in need is growing, while the complexity of their needs is increasing”\(^2\). The difficulties facing the sector come from many angles, with challenges from both within the sector and from developments in government policy. Below, we briefly explore the most pressing of these challenges.

Central and local government, as well as those within the adult social care sector, need to address each of these to prevent an imminent crisis in adult social care in the UK.

Funding

The adult social care sector has been struggling with long-term underfunding, with councils in England expected to be facing a £4.3 billion shortfall by 2020\(^6\). As things stand, a significant proportion of funding for adult social care is paid for by local authorities (there are also some self-funders and some who are part self-funded and part local authority funded) who in turn receive their budgets from central government\(^7\). Local authorities have had their budgets cut by central government continuously since 2005, which has limited the availability of funds for the adult social care sector. While the current government has ring-fenced spending on the NHS, Education, Defence and Foreign Aid, local government budgets sit outside of this\(^8\). Non ring-fenced departments have been asked to assess how a further budget cut of between 25-40% over the course of this parliament would affect services, raising the spectre of continued underfunding for the care sector. To put recent social care funding pressures into perspective, while health spending increased from £97.5 billion in 2010-11 to £116.4 billion in 2015-16 (an increase of 19.3%), social care funding has decreased from £14.9 billion to £13.3 billion (a reduction of 10.7 per cent) – and more in real terms, when the ageing population is taken into account\(^9\).
The difficulty in finding a solution to care funding

The difficulty in finding a solution to funding adult social care is by no means a new phenomenon. Solutions have in the past been debated, but have often been delayed or scrapped due to political disagreement. Tony Blair, in his first speech at the Labour Party Conference as Prime Minister in 1997, said of young people in the UK: “I don’t want them brought up in a country where the only way pensioners can get long-term care is by selling their home.” Despite this rhetoric, there was little concrete action taken. The latest development regarding the delay on the so called “cap” on adult social care costs continues to demonstrate the problem of finding a long-term solution to the problem of funding adult social care. The Care Act 2014 set out provisions for a “cap” on care costs at £72,000 and a new more generous means test. But this appears to have been postponed indefinitely – implementation is now not expected until 2020, if it happens at all.

Increased demand for care services

An ageing population will mean that an already stretched adult social care sector will see a significant increase in demand for both domestic and residential adult social care. In 2012, there were approximately 2.5 million over 65s in the UK with at least one limitation of activities of daily living (ADL). With the increase in the number of over 65s over the next 20 years, by 2037 it is expected that the number of older people with ADL limitations will have risen to 4.2 million (if the rates of disability by age remain the same).

Such a significant increase means that the adult social care workforce will also need to rise substantially in order to meet demand – something which will be very difficult to achieve if underfunding of the sector continues to persist. Crucially of course, disability rates by age may not remain the same but could rise or fall. Indeed, recent research from the ILC-UK has shown that prevalence rates of serious illness – which can be linked to incidences of disability – have actually risen among those over 80 since 2002.

The introduction of the National Living Wage

The first Budget since the 2015 General Election included the proposed introduction of a new National Living Wage to replace the current Minimum Wage. For those aged 25 and over, the new Living Wage will be £7.20 an hour from April 2016, before rising to over £9 an hour by 2020. Meeting the new wage will be a significant challenge for the adult social care sector. Adult social care work, both in the public and private sector, has historically been low paid, and average wages have actually been falling in the sector. This is, in part, a consequence of long run underfunding putting increasing financial pressures on care providers. Research has also indicated that approximately 10% of care jobs actually pay less than the current National Minimum Wage, due to staff only being paid for contact hours. Along with negotiating the already serious challenges of balancing increased demand with squeezed funding, the adult social care sector will now have to fund a substantial pay increase for many of its employees.
The UK Homecare Association, in an open letter to the Chancellor, warned that while councils provide the funds for most of the care provided in the UK, they are not paying care providers enough. Their research indicates that the new National Living Wage will mean that the total hourly cost for these firms to deliver care will be £16.70; however currently the average hourly rate paid to these firms by councils is only £13.66\(^\text{17}\). With care providers already struggling to meet minimum wage requirements, serious questions are being asked about how the care sector can sustainably meet this new living wage. The Resolution Foundation has estimated that meeting the new wage requirements in the social care sector could require an additional £1 billion of public funding up to 2020, relative to a situation in which funding rises just in line with inflation and rising demand\(^\text{18}\).

**Migration policies and their impact on the adult social care sector**

Migrant workers are subject to different migration laws depending on whether or not they are from the EU. EU migrants – that is people coming from EU countries into the UK – are, generally, freely able to move to the UK for work due to the free movement of labour principle, which is one of the cornerstones of the European Union. Non-EU migrants, on the other hand, can generally only enter the UK for work purposes by obtaining a work permit through the so called points-based system. Below, we set out how migration policy affects these two groups with reference to adult social care.

**A brief word on the terms “migrant” and “net migration”**

**Migrant**

The term migrant may be defined in terms of country of birth, regardless of citizenship, or in terms of citizenship. In this report, we use the term migrant when referring to those who were not born in the UK, irrespective of their citizenship, since it is “consistent, and corresponds to a common understanding of migration”\(^\text{19}\).

**Net migration**

Migration is the movement of people into and out of a country over time. If, in any given year, the figure for net migration is positive, this means that more people came into the country than left during that year. On the other hand, if net migration is negative then this means fewer people came into the country than left in that year.

**Non-EU migration**

From 2008, all existing visa and work permit systems were replaced with a single points-based system, made up of five tiers. This tiered system is the main mechanism for managing international flows of workers into the UK from outside of the EU. There are other routes for non-EU people to enter the UK including specific routes for those who are coming in as students and those who are seeking asylum. Non-EU citizens, who are family members of those able to live in the UK, may also be allowed entry into the country under certain circumstances.
In the UK, migration policies related to the care sector have been subject to significant change. While in the past, non-EU citizens could apply for a working permit for care work, the same opportunities today are strongly limited both for low-skilled and for high-skilled workers.

Low-skilled workers

Since 2008, no Tier 3 visas – i.e. visas for low-skilled workers filling specific temporary labour shortages – have been allocated, and in March 2013, the Prime Minister David Cameron announced that Tier 3 was to be ‘shut down completely’.

High-skilled workers

Tier 2 – designed for skilled workers from outside the EU who have an offer of skilled employment in the UK – is the primary route for non-EU migrants seeking work in the UK. Tier 2 applicants must be educated to graduate level, be sponsored by a UK employer and must attain enough points, awarded on the basis of scarcity of skills and salary.

An annual cap on Tier 1 and 2 non-EU workers of 21,700 has also been introduced, with a manifesto promise from the Conservatives to maintain the cap at that figure. This cap was reached for the first time in June 2015.

Focus on: The UK’s points-based immigration system

The UK’s points-based immigration system is the main way in which non-European migrants can apply to work in the UK. It contains:

- **Tier 1**: This visa category is for ‘high-value migrants’ from outside Europe and covers entry of entrepreneurs, investors, and those few people who come under the ‘exceptional talent’ visa.

- **Tier 2**: This category is for ‘skilled workers’ from outside Europe with a job offer in the UK. It includes skilled workers who are transferred to the UK by an international company, skilled workers where there is a proven shortage in the UK, ministers of religion and sportspeople.

- **Tier 3**: This category was designed for non-EU, low-skilled workers, filling specific temporary labour shortages.

- **Tier 4**: This category is for students aged over 16 from outside the EU who wish to study in the UK. Applicants must have a place at a registered UK educational establishment before they can apply.

- **Tier 5**: This category contains six sub-tiers of temporary workers including creative and sporting, charity, religious workers, and the youth mobility scheme.
The latest Tier 2 Shortage Occupation List includes a series of roles related to the health sector, such as “social worker working in children’s and family services”, or “specialist nurse working in neonatal intensive care units”, but there is no specific mention of health and care services for older people. Indeed, since 2011, senior care workers and social workers have not been included in the Tier 2 shortage list. In October 2015, the government agreed to place nurses on the Shortage Occupation List on a temporary basis. This is pending a full review by the Migration Advisory Committee on whether there is a shortage of nurses or specific nursing job titles which it would be sensible to fill through non-EU migration. This review relates to nurses across both the health and social care sectors.

How non-EU care workers could be affected by the new income threshold

New changes to the immigration rules will have implications for the retention of adult social care workers already working in the UK in professional roles, as well as the future recruitment of professionals from outside the EU. These changes state that any worker who entered the UK after 6 April 2011 on a Tier 2 visa will need to earn £35,000 to apply for indefinite leave to remain. Under the new rules, a professional may only remain in the UK for a maximum of six years if the high income threshold is not satisfied. After this time, the worker will need to leave the UK, as further leave cannot be obtained on the basis of employment.

Focus on: anticipated migration policies relating to non-EU migrants

More recently, the government’s planned immigration policies have become increasingly restrictive, with the intention to reduce net migration back to the levels of the 1990s – i.e. “tens of thousands not hundreds of thousands”.

In September 2015, the government introduced a new Immigration Bill with the stated purpose of weakening the UK’s economic dependence on migrant workers. The government is seeking to fulfil this objective by creating more training opportunities and apprenticeships for British workers funded by a new Tier 2 visa levy on businesses, and through a crackdown on employers who exploit migrant workers by paying below the minimum wage. In his “Speech on Immigration” on 21 May 2015, the Prime Minister promised to “make illegal working a criminal offence in its own right” with stark punishments for workers, who can be detained and repatriated, and civil penalties for employers.
Earlier this year, the Royal College of Nursing warned that this new policy development could affect up to 3,300 nurses currently working in the UK\textsuperscript{28}. As the new income threshold does not apply to job roles that are on the Shortage Occupation List at any point, nurses will now be exempt in April 2016. However, it remains unclear how a number of job roles within the social care workforce will be affected.

**The Migration Advisory Committee (MAC) and Skills Shortage List**

The government has issued a “Call for Evidence” to the Migration Advisory Committee (MAC) which will appraise the most salient aspects of the Immigration Bill. For instance, the MAC will evaluate how to restrict Tier 2 (general) recruitment “to genuine skills shortages and highly specialist experts only […] with flexibility to include high value roles, key public service workers and those which require specialist skills”.

The MAC is also in charge of assessing the impact on net migration of increasing the minimum income threshold to “ensure that Tier 2 migrants are not undercutting the resident labour force”\textsuperscript{30}.

**EU migration and the referendum**

Because the UK is part of the EU, it is subject to the free movement of labour laws that underpin the European Union. But the UK government is seeking to reduce the incentives for workers from the EU to come into the UK. The government has, for example, proposed to restrict EU workers’ access to tax-credits for low-income earners for a period of four years after entering the UK, as well as stopping child tax credits for children who do not live in the UK\textsuperscript{31}.

While the government says it is confident that curbs on benefits for EU migrant jobseekers can be achieved without changing existing EU law, restricting in-work benefits to EU migrants would most probably require a treaty amendment. This is because the Treaty on the Functioning of the European Union includes the right for citizens of EU countries not to be discriminated against with regards to employment and remuneration on the grounds of nationality\textsuperscript{32}. Moreover, EU law prohibits discrimination on the basis of nationality regarding the “social and tax advantages” that a worker native to that member state would be entitled to. The Court of Justice has added further clarification by ruling that these ‘advantages’ do include welfare benefits\textsuperscript{33}.

Then there is the wider question about the UK’s future as an EU member state. The government is committed to holding a referendum on the UK’s membership of the EU relatively early in this parliament. But if the UK does indeed leave the EU, or renegotiate its membership with the EU, this could, conceivably, be accompanied by the UK opting out, or at least partially opting out of the free movement of labour agreement currently in place between the EU and its member states. The UK may, for example, seek to draw up its own list of countries whose citizens would need a visa to work in the UK, and that might include migrants from some parts of the EU but exclude others.

For the time being, this is all speculation, but an EU referendum and the uncertainty it creates could, in itself, act as a deterrent to those who might otherwise want to come and work in the UK.
A quick recap

In summary, the adult social care sector is facing a funding squeeze which is affecting service delivery. Having faced years of underfunding, it is struggling to meet rising demand for care and to pay minimum wages to its staff. Anticipated policies, including further cuts to local authority budgets and the introduction of a new Living Wage, are likely to exacerbate longstanding issues facing the sector. Meanwhile, migration policy is placing increased restrictions on non-EU migrant labour – particularly unskilled migrant labour – which is preventing non-EU migrants from being able to join the UK’s adult social care workforce. While EU migrants can still enter the UK in accordance with the EU’s free movement of labour principles, the UK government is seeking to curtail EU migrants’ rights to claim benefits. And over the longer term, the UK’s pending referendum on its membership of the EU could create uncertainty about what its future relationship with the rest of Europe will look like. This includes its relation to the movement of labour across the continent.
The role of migrants in the social care workforce

Key points

• The adult social care sector is highly reliant on migrant labour with nearly 1 in 5 care workers born outside of the UK.

• Non-EU migrants account for the greatest number and proportion of the migrant care workforce – some 191,000 people out of a total of 266,000.

• Recent changes to migration policy have resulted in a falling share of migrant care workers coming from non-EU countries and a rising share coming from EU countries.

• Within the care sector, migrants play a particularly prominent role in providing direct care to those in need, as well as professional support.

• Private care providers utilise migrant care workers to a greater extent than local authority run care providers.

• London and the South East are particularly reliant on migrant workers – nearly 3 out of every 5 care workers in London were born abroad.
About this chapter

This chapter provides a detailed examination of the roles and characteristics of migrant workers within the overall adult social care workforce. To achieve this, we have analysed the latest available data from the National Minimum Dataset for Social Care (NMDS-SC) – the largest dataset available on the care workforce. All statistics on the care workforce relate to the workforce in England.

What is the current composition of the adult social care workforce?

An estimated 1.45 million people work in the adult social care sector, accounting for a total of 1.52 million jobs. Even though the great majority of adult social care workers in England are born in the UK, the sector is heavily reliant on migrants, who represent 18.4% of the workforce, with approximately 75,000 of them coming from within Europe, and over 190,000 from outside Europe (see Table 1).

Table 1: Size of the adult social care workforce, by country of birth

<table>
<thead>
<tr>
<th></th>
<th>Adult Social Care Workforce</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born in the UK</td>
<td>1,183,618</td>
<td>81.6%</td>
</tr>
<tr>
<td>Born in EU, outside the UK</td>
<td>75,002</td>
<td>5.2%</td>
</tr>
<tr>
<td>Born outside the EU</td>
<td>191,380</td>
<td>13.2%</td>
</tr>
<tr>
<td>All adult social care workers</td>
<td>1,450,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Author’s calculations from NMDS Workers’ File and NMDS-SC 2014 report. Note: establishments with questionable country of birth data have been excluded, therefore the estimation sample consists of 375,001 observations.
Focus on: How has the migrant composition changed over time?

Since 2011, when senior care roles were removed from the Migration Advisory Committee’s skills shortage list, the proportion of UK born workers employed in the adult social care sector has risen by 2.9 percentage points, from 78.7% to 81.6%, while the proportion of migrants has fallen accordingly. In addition, a likely consequence of recent immigration policies has been a reallocation of migrant labour within the English social care workforce, away from non-EU migrants and towards EU migrants. In 2011, 22% of all migrants working in the English care workforce were born in Europe, rising to 27% by 2015. Up to 40% of EU migrant carers arrived in the UK after 2011, while 86% of non EU migrants in the care workforce arrived before 2011.

To really understand how substantive this change has been, it is worth looking at the shift within the context of 50 years’ worth of information on the adult social care workforce (see Figure 1). Among migrant care workers who arrived in the UK between 1966 and 2002, non-European migrants consistently accounted for a greater share than European migrants. The situation started to change in 2003/2004 as the A8 countries joined the EU, when the share of new entrants accounted for by European migrants rose by nearly 10 percentage points. However, it is between 2010 and 2014 that there is the starkest change, with the proportions reversing so that by the end of the period, EU migrants account for the overwhelming share of new entrants (80%). It is worth noting however, that despite the recent shift in the make-up of migrants joining the adult social care workforce, non-EU migrants continue to account for, by far, the greatest proportion of migrants working in the sector today.

**Figure 1: Share of EU vs. non-EU migrants in the Adult Social Care workforce, by year of arrival in England**

Source: Author’s calculations from NMDS Workers’ File 2015.
What are the primary countries of origin for the migrant care workforce?

The shift within the migrant care workforce is reflected in the top ten countries of birth for migrant workers in the social care sector over the last twenty years (see Table 2). Among care workers who arrived in the UK between 1995 and 1999, 85% were born outside the EU, with Commonwealth countries such as India and Nigeria accounting for the largest share. By contrast, among those who arrived between 2007 and 2014, only three in five were born outside the EU, with Polish workers and Romanians representing over a quarter of the newest recruits.

Table 2: Top 10 countries of birth of non UK born workers by year of arrival in the UK (national)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
<td>%</td>
<td>Country</td>
<td>%</td>
<td>Country</td>
</tr>
<tr>
<td>Non-EU</td>
<td>85%</td>
<td>Non-EU</td>
<td>89%</td>
<td>Non-EU</td>
</tr>
<tr>
<td>EU (non-UK)</td>
<td>15%</td>
<td>EU (non-UK)</td>
<td>11%</td>
<td>EU (non-UK)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>11%</td>
<td>Zimbabwe</td>
<td>21%</td>
<td>Poland</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>11%</td>
<td>Philippines</td>
<td>11%</td>
<td>Philippines</td>
</tr>
<tr>
<td>India</td>
<td>7%</td>
<td>India</td>
<td>8%</td>
<td>India</td>
</tr>
<tr>
<td>Philippines</td>
<td>6%</td>
<td>Nigeria</td>
<td>7%</td>
<td>Nigeria</td>
</tr>
<tr>
<td>Jamaica</td>
<td>5%</td>
<td>Jamaica</td>
<td>5%</td>
<td>Zimbabwe</td>
</tr>
<tr>
<td>Ghana</td>
<td>4%</td>
<td>South Africa</td>
<td>5%</td>
<td>Ghana</td>
</tr>
<tr>
<td>South Africa</td>
<td>4%</td>
<td>Ghana</td>
<td>4%</td>
<td>South Africa</td>
</tr>
<tr>
<td>Kenya</td>
<td>3%</td>
<td>Poland</td>
<td>3%</td>
<td>Slovakia</td>
</tr>
<tr>
<td>Pakistan</td>
<td>3%</td>
<td>Pakistan</td>
<td>2%</td>
<td>Lithuania</td>
</tr>
<tr>
<td>Germany</td>
<td>2%</td>
<td>Kenya</td>
<td>2%</td>
<td>Mauritius</td>
</tr>
<tr>
<td>Other</td>
<td>44%</td>
<td>Other</td>
<td>33%</td>
<td>Other</td>
</tr>
</tbody>
</table>

Source: NMDS-SC 2015 National Key Statistics.
A female workforce?

The adult social care sector is still dominated by women. More than 8 in 10 workers are women (82.5%), with the proportion rising to 84.9% among UK born care workers (see Table 3). Care work has often been perceived as “women’s” work, not only because it involves qualities typically considered “feminine” by society, but also because it requires a relatively low level of education, and women have historically been less well educated than men38.

The proportion of women among non-EU migrants is ten percentage points lower (75.2%) than among the UK born workforce and, indeed, some see non-EU migration as a remedy to the excessive “feminisation” of the care workforce39.

Are migrant care workers younger than those who are UK born?

The adult social care workforce is reliant on middle-aged and older workers. There are 193,000 people who are either approaching or above State Pension age working in the care sector while the median age for care workers is 44 (see Table 3). By contrast, migrant care workers are substantially younger (median age 40), with migrants coming from Europe especially young (median age 37).

<table>
<thead>
<tr>
<th>Demographic profiling of the social care workforce, by country of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born in the UK</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td><strong>% Females</strong></td>
</tr>
<tr>
<td><strong>Average age</strong></td>
</tr>
<tr>
<td><strong>Median age</strong></td>
</tr>
<tr>
<td><strong>% 60 and older</strong></td>
</tr>
</tbody>
</table>

**Work Characteristics**

<table>
<thead>
<tr>
<th>% Full time</th>
<th>51.5%</th>
<th>63.6%</th>
<th>51.1%</th>
<th>52.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Permanent</td>
<td>88.2%</td>
<td>83.6%</td>
<td>72.3%</td>
<td>85.8%</td>
</tr>
</tbody>
</table>

Source: Author’s calculations from NMDS-SC individual workers data file, 2015.
Note: establishments with questionable country of birth data have been excluded.
Which roles do migrants fill in the care workforce?

Out of the total care workforce, the majority (some 1.1 million) work in direct care roles, which are typically hands on, relatively low-paid jobs that require few formal skills. The highest qualification required for occupational competency is a level 2, equivalent to GCSE grades A*-C.

Among the 266,000 migrants working in the sector, the vast majority are in direct care roles (approximately 200,000), and of those migrants working in direct care circa. 150,000 were born outside of Europe (for a detailed definition of job roles, see appendix). At the same time, nearly a third of the 65,000 care workers employed in high-skilled professional roles, such as registered nurses and occupational therapists, were born outside the EU (see Figure 2).

**Figure 2: Structure of the adult social care workforce: job role and country of birth**

<table>
<thead>
<tr>
<th>Job Role</th>
<th>Born outside the EU</th>
<th>Born in EU, outside the UK</th>
<th>Born in the UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Care</td>
<td>14.0%</td>
<td>5.3%</td>
<td>80.8%</td>
</tr>
<tr>
<td>Manager/Supervisor</td>
<td>8.1%</td>
<td>3.1%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Professional</td>
<td>29.0%</td>
<td>8.7%</td>
<td>62.4%</td>
</tr>
<tr>
<td>Other Job Roles</td>
<td>6.9%</td>
<td>4.7%</td>
<td>88.4%</td>
</tr>
</tbody>
</table>

Source: Author’s calculations from NMDS Workers’ File and NMDS-SC 2015 report. Note: establishments with questionable country of birth data have been excluded.
Which service groups employ migrant workers?

Among migrant care workers, over 150,000 are employed in care homes, while 81,000 work in adult domiciliary care (home care) and an additional 35,000 work in other care workforce roles such as adult community care services. This broadly mirrors the split across the total care workforce – with significantly more people working in care homes than in domiciliary care (see Table 4).

How are migrant workers distributed by type of provider?

Approximately 75% of the care workforce (over a million people) are employed in the private sector. A larger proportion of migrants work in the private sector than across the overall workforce.

For instance, 74% of UK born care workers work in the private sector, but this rises to over 81% of migrant care workers born in Europe and 77.4% of non-European migrants (see Figure 3).

Table 4: Which service groups employ migrant workers?

<table>
<thead>
<tr>
<th>Service Group</th>
<th>UK</th>
<th>Non-EU Migrant</th>
<th>EU Migrant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care homes with nursing</td>
<td>76%</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>Care homes without nursing</td>
<td>84%</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Domiciliary care</td>
<td>83%</td>
<td>13%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Where do migrants work?

London has a very high concentration of migrant workers, with nearly 60% of its care workforce born abroad, and approximately 85% of those migrant workers born outside of Europe. (see Table 5) (Indeed, one in four migrant care workers are working in London.) The impact of restrictive non-EU migration policies on the capital could therefore be particularly problematic for the future delivery of care. The South East also has a relatively high proportion of migrant workers – with one in four care workers born abroad. By contrast, other regions rely far less heavily on migrant workers. In the North East, for example, over 95% of care workers are UK born, reaching a peak of 97.7% in Durham.
For these regions, restrictive migration policies may not have such an immediate impact but they will remain reliant on attracting sufficient UK born residents to meet future demand.

The geographic diversity is also reflected in the distribution of non-EU workers by establishment. Approximately 40% of establishments employ no workers born outside the EU, while in 10% of establishments, nearly half of the workforce (45%) were born outside the EU.

London has a high proportion of migrant workers more generally (not just in the care sector) and has experienced a significant increase in the number of care home residents over a 10 year period.

Between 2001 and 2011, London experienced a 9.4% increase in the number of people over the age of 65 in a care home – the largest increase of any UK region in England and Wales. But there is much diversity even within London.

A number of London boroughs saw dramatic rises in the number of care home residents, with Kensington and Chelsea, and Islington both seeing a doubling in older care home residents over the period. By contrast, the boroughs of Hackney and Harrow saw falls of around 20% in the number of older care home residents. These stark differences demonstrate how demand for care can be highly localised.

### Table 5: Geographical distribution of migrant care workers

<table>
<thead>
<tr>
<th>Region</th>
<th>Born outside the EU</th>
<th>Born in EU, outside the UK</th>
<th>Born in the UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>3.0%</td>
<td>1.3%</td>
<td>95.7%</td>
</tr>
<tr>
<td>North West</td>
<td>6.3%</td>
<td>2.4%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>6.3%</td>
<td>2.7%</td>
<td>91.0%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>9.4%</td>
<td>3.3%</td>
<td>87.3%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>10.6%</td>
<td>3.6%</td>
<td>85.8%</td>
</tr>
<tr>
<td>South West</td>
<td>7.6%</td>
<td>6.8%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Eastern</td>
<td>14.3%</td>
<td>6.2%</td>
<td>79.5%</td>
</tr>
<tr>
<td>South East</td>
<td>16.5%</td>
<td>9.0%</td>
<td>74.5%</td>
</tr>
<tr>
<td>London</td>
<td>50.2%</td>
<td>9.0%</td>
<td>40.7%</td>
</tr>
</tbody>
</table>

Source: Author’s calculations from NMDS-SC individual workers data file, 2015.
Note: establishments with questionable country of birth data have been excluded.
Figure 4: Increase in care home populations (2001-2011)

A quick recap

In summary, migrants and especially non-EU migrants make up a sizeable share of the adult social care workforce. In particular, migrant care workers providing direct care and professional support to those in need, are concentrated among private care providers and make up the majority of the care workforce in London and a significant proportion in the South East. But why do migrants play such a key role in the English adult social care sector, and what are the demand and supply-side factors drawing them into the care workforce? We will now address these questions.
Why do migrants work in the English adult social care sector?
Employer and migrant perspectives

Key points

- The care sector’s overall vacancy rate of 4.8% is significantly higher than the vacancy rate for the UK’s labour force as a whole – 2.6%. The care sector is therefore significantly less able to fill new job openings.

- Many UK born workers decide to work in sectors other than adult social care which is perceived to be low in pay, low in status, and with poor opportunities for progression.

- As a result, employers face a shortage of workers relative to demand for care, exacerbated by the relatively older age of the current social care workforce.

- When asked about the benefits of employing migrant workers, some employers have said that they find them more reliable, flexible, and better qualified than UK born workers and that they are able to pay them lower wages than comparable UK born workers.

- Migrants are attracted to the care sector for economic reasons. Even though it is poorly paid within a UK context, it pays a better wage than a job in many migrants’ home countries and it offers opportunities to move on to jobs in other sectors, both in the UK and within their country of origin.

- Migrants also choose the care sector out of a genuine desire to help older people, as a method of improving their English skills, and simply as a way to move to the UK.
About this chapter

This chapter reviews existing literature and evidence about why migrants work in the English social care sector – looking at previous research into employer and migrant perspectives. We also provide additional insight into migrant perspectives by presenting material from a series of interviews with migrants currently working within the adult social care sector.

Migrants needed: The employers’ perspective

“We don’t have a skill shortage coming up to 2030, we have it now. Why do we think it’s hard to get people into this job? Well I think, for one, it is hard work for most people... and people don’t want to do that if they’re being paid less than the minimum wage.”

Manager of care agency

Migration as a response to workforce shortages

A key driver for recruiting migrant social care workers in England has been to address staff shortages. In their 2013/14 report on the state of care homes in England, the Care Quality Commission found that one in five nursing homes did not have enough staff on duty to ensure residents received good, safe care. Moreover, the adult social care sector suffers from very high vacancy rates for many adult social care roles. Indeed, the care sector’s overall vacancy rate of 4.8% is significantly higher than the rate for the UK’s labour force as a whole – 2.6%. With an estimated 71,600 unfilled vacancies at the last count, the adult social care sector appears to find it particularly challenging to fill new job openings by comparison to the rest of the economy. The care sector also finds it particularly difficult to retain its staff – with a turnover rate of 23.9%. This means that around one in four employees will leave their employer during the year. It is worth noting that some jobs suffer from far higher turnover rates than others within the sector. For instance, care workers in the adult social care sector have a turnover rate of 29.7% meaning that roughly one in three will leave their employer during the year. Conversely, registered managers have a turnover rate of 12.3%.

Staff shortages stem from three main issues: the unattractiveness of working in the care sector, the ageing of the UK born adult social care workforce and rising demand for care among a growing older population. We will explore each of these in turn.
An unattractive sector

Lack of full time work and training

The adult social care sector in England is characterised by flexibility, fragmentation, insecurity and instability\(^48\). A large number of jobs are not offered on a full-time permanent basis, and indeed, only about half the workers in the sector are full time (vs. 70% in the general workforce), and about 85% are employed permanently (vs. 93% in the general workforce)\(^49\). While some prefer the flexibility of part-time working, others do not. In addition, there is very little training, with many new care workers receiving just a couple of days’ shadowing before being expected to work unsupervised\(^50\). The new Care Certificate may, in part, address some of these issues. It outlines an identified set of standards that health and social care workers should adhere to in their daily working life. The Care Certificate is aimed at ensuring workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support\(^51\).

Many care staff are paid the minimum wage and some are paid even less

"The minimum wage for that job is not enough. And there are a lot of agencies that pay minimum wage to the employees. Maybe that’s why one day there won't be enough staff for this job because no one wants to do that job for that amount of money. It’s a very difficult job."

Female, 27, from Bulgaria, who works for a homecare agency

Pay in the sector is low; many workers are on the minimum wage and the average pay for frontline care roles in 2013-14 was £7.20 per hour, comparing unfavourably to a living wage at that time of £7.45 outside London and £8.55 in London\(^52\). Moreover, one in 10 care jobs actually pay below the minimum wage as a result of employers only paying for contact hours and not travel time between visits\(^53\). Indeed, care workers often have difficulties exercising their employment rights. This is partly explained by the fact that just 24% of care workers are members of a trade union and many employees work in isolation from their colleagues, which limits care workers’ collective bargaining power\(^54\).

Aside from the practical difficulties of working in the sector, there is also a problem with the way that the work is perceived. In the words of Bill Mumford, head of the care home charity, MacIntyre: “There’s a view now that if you can’t do anything else, you do care\(^55\).”

1 in 10 care workers may well retire from the workforce within the next few years

11.5% are aged 60+
The low status of care work is partly the result of its perceived feminine nature. Personal care roles have traditionally been filled by women and it has been argued that “low pay, limited career opportunities and general poor working conditions in the [care] sector reflect a historical undervaluing of women’s work and a high degree of gendered occupational segregation.”

“It is very, very difficult, because you’re looking after a human being... if you don’t do well, you are risking your career, risking your reputation... so you have to be alert all of the time.”

Female, 51, from Nigeria, works in residential care

Working in the social care sector can be hard work with care workers facing high risk situations on a day-to-day basis which can be extremely stressful. Indeed, care workers may be subject to abuse from those they care for. A survey undertaken by Skills for Care found that a majority of social care and support staff have faced verbal (93%) and physical (53%) abuse. In this regard, the combination of low pay, stressful working situations and little opportunity for career progression is a particularly potent combination deterring people from joining the social care sector.

Given this mix of reasons, employers in the care sector say they struggle to recruit UK born workers in sufficient quantity to match the demand for care. However, we should bear in mind that there are huge geographical differences, and the attractiveness of the care sector varies according to the state of specific local labour markets and the reputation of care providers in that area.

An older workforce

The adult social care workforce is relatively old. With approximately one in ten aged 60 or above, a significant proportion of the sector could leave through retirement over the next few years. A large proportion of employees only start working in the sector late on in their careers; indeed a quarter of the UK born workforce, and about one in five migrants, start work in the sector aged 44 or over.

Young people who start working in the sector often do not see it as a long-term career, and instead use it as a springboard to pursue work elsewhere in the better paid and more career-oriented health sector. There is little in the way of high quality training or apprenticeships to entice them to remain in the care sector, with just 34% of health and social care apprentices receiving both on- and off-the-job training, and one fifth receiving no training at all. Unsurprisingly, adult social care employers struggle to retain younger workers (below 30) compared with older workers.

Given that some providers find it difficult to attract sufficient young, UK born workers into the care sector, and that a significant number of older UK born care workers are likely to retire in the near future, it arguably makes sense for some care providers to try to employ migrant labour to fill the care workforce gap.
Migrants can be more attractive to employers than UK born workers

While the decision to employ migrants might, in part, be a response to workforce shortages, some employers also see them as attractive employees in their own right. Past research has shown migrants to be, on balance, better qualified, better trained and often perceived by employers as being more reliable and flexible than UK born care workers.

Migrant care workers have higher skill levels than UK born care workers

Employers and HR managers in the care sector have acknowledged that migrant workers tend to be better qualified (usually in health sector terms) than individuals recruited locally.

For the purpose of this report, we have calculated the extent to which migrant workers have higher qualifications than non-migrant workers.

Figure 5 shows that, even after taking into account factors such as gender, age and years of experience in the sector, migrant workers (and particularly non-European migrant workers) are significantly more likely to be high skilled (have a qualification equivalent to level 4 or above) compared to UK born workers. There is less than a 10% chance of a UK born worker holding a level four qualification. However, this rises to 15% for equivalent migrant workers born outside of the EU.

Employers may therefore see migrants as good value for money, since they come to the UK with experience and a care-related qualification obtained in their home country while they accept pay at the “unqualified” rate.

Figure 5: Skilled Adult Social Care Workers by Country of Birth

Source: Author’s calculations from NMDS-SC individual workers data file, 2015.
Note: the chart reports the average adjusted probability of being “high skilled” controlling for age, gender, region and years of experience in the sector.
Case study – Cesar, 60, originally from the Philippines

Cesar came to social care work late in his career having worked for many years in North Africa as an accountant. He came to the UK 12 years ago, but couldn’t find work as an accountant because his qualification was not recognised. On his wife’s suggestion he found a job as a care assistant in a care home, and he now works as a team leader. Although it took a while to adapt to the regulations of the work environment, he really enjoys the job and the relationships he can build with the care home residents.

He thinks it’s important to have male carers because some male residents prefer to have a man and they should be given a choice. However, he believes that men don’t generally go into care work because they don’t like the more menial aspects, “and then also, male people, maybe they are thinking that this kind of job is for women, caring for people.”

Migrants are ‘flexible’

When asked why they hire migrant workers, employers and HR managers have replied that they are “hard working”, “flexible”, “reliable”, and generally able to empathise with older people, especially if they are from countries such as the Philippines. Employers also report that migrant care workers have a better “work ethic”; they “don’t take time off without genuine cause” and “they’re more willing to do extra work if it’s available.”

“It is a hard sector to work in and sometimes, because of our background, we are used to things like that, so we don’t think it’s anything, so we do it. We are thorough. We are committed. We do it well even when it is hard.”

Female, 51, from Nigeria, works in residential care

Unfortunately, in some instances, such flexibility could ultimately lead to exploitation of migrant workers. The Kingsmill Review highlighted that ‘migrants are particularly vulnerable to exploitation due to a lack of awareness about their workplace rights, and in some cases working visas that tie them to particular employers, which restricts their ability to leave and can make it difficult for them to raise concerns about treatment.’ The review noted how one care home had taken advantage of this situation, and deducted large amounts of money from the workers’ pay for housing, uniforms and training – “almost certainly illegally.”
Working in care: The migrants’ perspective

There are a number of incentives for foreign born workers to migrate to the UK and to work in the English social care sector. These incentives can be divided into purely economic incentives, as a way to earn a living in the UK and to send money home to relatives, and broader non-economic incentives, ranging from a wish to move to the UK through to a genuine desire to help older people.

Economic incentives

Even though the care sector is relatively poorly paid for migrants, for some it is still a higher wage than they could earn in their home country. Migrants from countries with poor economic opportunities are able to use care work in the UK as a means of sending money back to their families, for example to support children’s education or to buy a house. There is also the hope that employment in the care sector could be ‘a stepping-stone into other forms of employment both in the UK’, for example in the NHS, or as a springboard into better employment ‘when returning to home countries, through access to training, experience and improved job opportunities’.

Case study – Darina, 27, originally from Bulgaria

Darina moved to the UK from Bulgaria four years ago, “I wanted to go somewhere where I can have good education and where I can have opportunities to have a good job, a good career, to just invest something in my future and in Bulgaria, that’s not really possible.”

She has worked for three different care agencies and also as a live-in carer. Darina started studying part time to be a nutritional therapist a year ago, but wants to continue as a care worker until she qualifies because, “I want to do something more meaningful. Of course it can be very challenging, but there is that part of the job I really like, you can actually learn so much from your client. Because they are elderly people, they’ve experienced a lot.”

Her current contract is permanent, but in her previous agency work she was self-employed. “The agency I start with after I left live-in carer, wasn’t decent. It was very, very terrible. They did provide some online training for me, but it wasn’t nothing special to be honest. I had to learn while I was working, while at work.” She had to pay for her own training. “It’s not fair sending someone without training who is responsible, in a way, for someone else’s life. It’s very dangerous.”

She also felt that too many demands were placed on her, “It was too much. We would end up doing like 40 hours in a row, and no holidays, nothing like that. It was very difficult to take days off....The manager she was quite clever, she can manipulate in a way, because not many foreigners are aware of their rights here. So I wasn’t aware that I could say no. I’m self-employed so I don’t have to do that shift. But then she could turn around and say well okay, fine, you’re free to go. I’ll hire someone else....There are a lot of agencies like that out there.”
Broader incentives

“I have got that reward, when I see them smile. When I see them very happy and thank me for the service I have given them. It’s really motivating and makes me very happy.”

Female, 51, from Nigeria, works in residential care

Many non-EU migrants cite a wish to help others as a key motivation for working in the sector. This is particularly the case for those who come from the Philippines, many of whom have trained in their home country specifically for the purpose of working in the UK or the US. Migrants also see working in social care as a way of improving their English language skills. Sometimes they hope to gain experience before transitioning to another sector or entering higher education68.

For refugees, working in care may be attractive because they cannot find employment in another sector that matches or accepts their qualifications. Since the care sector requires few formal qualifications, relying more on interpersonal skills, it has been highlighted as an easier sector for such migrants to restart their lives in69. Other migrants choose to work in social care because of ‘a general desire to migrate to the UK’, believing it will afford them a higher quality of life and access to social security70.

Challenges faced by migrant care workers

Qualitative research suggests that non-European migrant workers are often aware of being discriminated against in terms of wages71. They report working longer hours than their UK born counterparts, being given anti-social shifts (at night and at weekends) and being given ‘the harder tasks’ or ‘more difficult residents’72. They also experience racism, both from care users and their employers73.

Living and working in the UK does not always live up to migrant care workers’ expectations. Research highlights that migrants do not always attain the standards of living they had hoped for. They may struggle with costs of living – including housing and transport costs, and have difficulties getting their qualifications recognised74. Some also find it hard to adapt to British culture, finding it difficult to understand attitudes towards older people, patterns of family care and nuances of language75.

Faced with a multitude of different issues and challenges, migrants can find it difficult to improve their circumstances. Non-European migrants are tied to their employer by a work permit and therefore have lower bargaining power. Indeed, even though theoretically work permit holders are entitled to change employers, in reality, only a prospective new employer can apply for the permit, making the worker powerless76.
Case study – Bernadette, 41, originally from Sierra Leone

Bernadette moved to the UK from Sierra Leone nine years ago as a live-in domestic worker with a family. She worked with the family for five years and applied for indefinite leave to remain. The process was very difficult, but her solicitor told her to persevere because if she went home she would never be able to return to the UK as a domestic worker given tightening immigration rules.

She works on a bank system 20-25 hours a week for two employers: an ‘extra care’ residential home and a domestic care agency. She doesn’t like this situation but says, “Well, that is what they’re giving you now so what can you do? You can do nothing. You just have to accept it.” She also feels the pay is too low: “To be honest it’s not enough but what can you do? You can do nothing.”

However, Bernadette likes her job, especially building a relationship with the clients so that they trust and value her, and feeling that she knows how to communicate with them.

She feels that employers should be more caring about their staff, not demanding too much from them. “They need to look after carers more. We are the ones out here busting ourselves, it’s not good. They should learn to respect us.”

Bernadette would now like to use her skills to work for the NHS as a community health worker with older people, to learn and move forward, as well as get better pay and conditions, “because essentially you need to learn more, you need to improve yourself.”

A quick recap

In summary, the care sector’s reliance on migrant workers is a consequence of both demand and supply side factors. UK born workers find the sector unattractive, due to its low pay, low status and insecure contracts so employers turn to migrant labour, which they report to be more flexible and reliable. Migrant workers also tend to come with higher formal skills than non-migrants and yet do not receive a wage premium. In turn, migrants are attracted to the care sector for economic reasons – even though it is poorly paid, it pays a better wage than a job in many migrants’ home countries and it offers opportunities to move on to jobs in other sectors, both in the UK and in their country of origin.
What might be the long-term implications of public policy?

Key points

- There are a number of plausible public policy approaches to ensuring that the future care workforce is sufficiently large, and well prepared to meet demand.

- Using scenario analysis, this chapter illustrates how the current status quo – which seeks to curb migration while continuing to underfund the care sector – could lead to substantive care workforce gaps. We project that by 2037, if working in care becomes increasingly unattractive and net migration falls, the workforce could have over one million fewer care workers, relative to demand, than is the case today.

- Alternative approaches that aim to meet adult social care workforce needs, either through greater migration, or by increasing the attractiveness of the sector, are unlikely to succeed. Both are still likely to result in large care workforce gaps by the end of the projected period.

- The least risky approach would be to raise both the attractiveness of working in care for UK born workers and encourage migrant labour to meet adult social care workforce needs. In our most optimistic scenario, where the sector becomes increasingly attractive and migration is higher than currently anticipated, by 2037, the care workforce will have 353,000 fewer care workers, relative to demand, than is currently the case.

- While this is a significantly smaller workforce gap than in our worst case scenario, it still implies a degradation in the overall delivery of care in England. It is arguably only through substantive policy change and a dramatic shift in the perceptions of UK born workers about working in the care sector that we will be able to generate sufficient workers to meet future demand without an increasing reliance on unpaid carers.

- Attracting more workers into the social care sector is likely to be a challenge. The UK is already close to what some economists call “full employment”, implying that the sector must actively compete with, and be successful in attracting workers from, other industries.
About this chapter

In this chapter, we seek to shed light on how different public policy decisions could lead to different outcomes for the social care workforce and ultimately for those receiving care in the longer term. Rather than relying explicitly on forecasting the future, we rely on scenario planning to understand what different futures for social care might hold.

Scenario planning, broadly defined in terms of building compelling narratives, discussions and dialogues on the future, is the method most closely followed in this report when seeking to assess the potential long run implications of policy.

Scenario planning is a useful means of identifying ‘early warning’ indicators that signal a shift towards a certain kind of future – whether good or bad. Given the difficulty in trying to predict what the world will look like at some distant point in time, scenario planning is a useful tool of analysis – challenging our basic assumptions of what the future might look like and correspondingly prompting us to develop a number of possible policy responses. It does not try to accurately predict the future, but identifies a limited set of examples of possible futures to provide a valuable point of reference.

In this regard, we build scenarios to consider how changes to public policy on migration and adult social care could affect the ability of the adult social care workforce to meet demand over the coming decades.

Our approach

The two big issues we want to consider in terms of their impact on the social care sector are the overall attractiveness of working in the care sector and migration policy. We want to understand how different configurations of each are likely to affect the delivery of care looking forward to 2037. To do this, we will assume that a key public policy goal is for the care sector to be able to adequately care for all of those in need, and that this ability is intrinsically linked to the number of care workers for every person in need of care.

The unattractiveness of working in the care sector and/or lower levels of migration are likely to reduce the potential supply of workers in a number of ways. The first could reduce the supply of workers by making it harder for care providers to hire new staff, as well as more difficult for the sector to retain existing talent. The sector’s relative level of attractiveness depends on many factors, including funding from central government, which helps support pay across the sector and opportunities for advancement, the type of work available within the care sector, and the public’s overall perception of working in care. Second, lower levels of migration could reduce the pool of available workers, making it harder to keep service delivery constant as demand rises. Increased migration will also, of course, affect demand for social care services, but because migrants are typically of “working age” (aged 15-64), when they first enter the country, they are likely to boost workforce numbers relative to demand.
Figure 6 below outlines the age structure of net migration per annum across the ONS’ various population projections. It shows that most of the net increase is projected to be concentrated between the ages of 20-30.

Figure 6: Annual net migration by single year of age: Various ONS projections 2018-

Source: ONS population projections
Introducing the scenarios

1 Sector unattractive, reduced migration

In a situation where the care workforce becomes increasingly unattractive to UK born residents but where public policy results in lower migration, there could be a growing gap between the number of workers needed to maintain standards of delivery, and the number of workers who actually join the social care workforce. Unless we assume heroic increases in efficiency across the care sector, this rising gap will result in greater levels of unpaid care (i.e. provided by family or partner) and, where this is not possible, rising levels of unmet need.

2 Sector unattractive, increased migration

Of course, this is not the only plausible outcome. Some policymakers may try to offset the problem of recruiting from within the UK by relaxing migration targets, and thus allowing the sector to plug workforce gaps by employing migrant labour. But future migration is likely to be highly uncertain, since it not only depends on internal migration targets, but also on international competition for (cheap) labour. In addition, it may well be the case that the number of migrant workers required to fill the gap far exceeds future inflows – even if migration surprises us on the upside. So rather than solving the problem, the end result of such a strategy may at best, be a moderate papering over of the gap in some years when net migration is highest.

3 Sector attractive, reduced migration

Alternatively, rather than looking towards relatively cheap migrant labour to fill care gaps, policymakers may seek to boost the attractiveness of the care sector for UK born workers. Better pay and working conditions could help attract new talent to the sector while ensuring that those already working within it are less likely to leave. But this is likely to be a tough task. The UK is already close to what some economists call “full employment” – a situation whereby almost all of those people within an economy that can work, are in work (see Figure 7. Employment rates are at record highs and unemployment has now fallen to approximately the rate it was before the financial crisis of 2008. In the absence of increased migration, there is little the care sector can do to increase its workforce, other than recruit from other sectors or entice school leavers into the care sector at a faster rate than other industries with which it competes for labour. Over the long term this may be possible, but it is likely to be a slow and gradual process requiring not only a dramatic reversal of the years of underinvestment in the sector, but also of the way in which care work is perceived.

4 Sector attractive, increased migration

Finally, policymakers could help to raise the attractiveness of the sector by increasing funding and by expanding the pool of available labour through a relaxation of immigration curbs. Arguably, this approach would give the sector the best chance of generating a workforce of sufficient size to meet demand. It may also be the case that the two policies are self-reinforcing. Raising the
Attractiveness of the sector for UK born workers could also help ensure that a higher number of migrants want to come and work in the sector. Yet such a policy response is quite the opposite of the current status quo.

Quantifying the implications of different scenarios

Through the modelling process, we aim to identify the extent to which there will be enough care workers to meet future demand for care. This approach considers the impact of migration and social care policy on plugging the gap between supply and demand. We therefore focus our modelling efforts around three key features: 1) demand for care, 2) the supply of workers and 3) the extent to which the supply of workers meets demand. The following subsections outline our approaches to each of these elements in turn.

Figure 7: Labour market slack (1997-2015)

Source: ONS

Estimating future demand for adult social care

First we endeavour to gain a rough idea of the future level of demand for adult social care. For this, we simply use the number of people in England over the age of 65 for each year up to 2037 as projected by the Office for National Statistics (ONS). Now, clearly, not everyone over 65 will need care, but a significant proportion will. So this provides a crude measure to assess the extent to which the supply of workers is able to meet future demand. Indeed, there are currently 6.8 people over the age of 65 for every care worker. We therefore need to assess how many additional care workers would be needed to keep that ratio constant over future years before calculating anticipated shortfalls. There is, of course, an implicit assumption here that the proportion of people over 65 in need of care will remain relatively static over time – when it may in fact rise or fall. But precise modelling of the future likelihood of care by different age bands is beyond the scope and scale of this report.
**Estimating future workforce supply**

To project future workforce supply, we first calculate the proportion of working age people in England working in the adult social care workforce today (which is around 4%). We then make certain assumptions about the extent to which this proportion rises or falls over future decades. Clearly the future make-up of the sector will be highly sensitive to the rate of change applied. In this context, we choose two gradual rates of change over the projected period – one positive rate for the optimistic scenario and one negative rate for the pessimistic scenario. In our optimistic scenario, we assume that working in the sector becomes gradually more attractive every year, so that the proportion of working age people working in the adult social care sector rises from around 4% today to close to 5% by 2037. By contrast, in our pessimistic scenario, we assume the opposite trend occurs, so that the proportion of working age people working in the care sector falls close to 3% by the end of the projected period. We think this approach is the most sensible for our purposes as it is arguably unlikely that adult social care will become dramatically more or less attractive for tomorrow’s workers.

**How plausible are the assumptions used?**

Unfortunately, there is little reliable trend data on how the adult social care workforce has evolved over the long term. Estimates from Skills for Care suggest there were around 1.56 million adult social care workers in 2010 falling to around 1.45 million in 2013, though their methods for calculating the overall size of the workforce changed during this time, making direct comparisons difficult.

An alternative approach is to look at ONS trend data on health and social work (which includes those working in the health service as well as adult social care at the UK level) over the last 18 years. In 1997, approximately 8% of people aged 15-64 worked in health and social work, and this rose to almost 10% by 2014 representing a significant rise, though other sectors, such as education, administrative and support services saw similar or greater rises. But with the UK now approaching full employment – a situation where all those who can work are in work – such dramatic positive shifts over the course of the next twenty years are perhaps unlikely (though not impossible).

Crucially, in order to significantly grow the workforce over future decades, the adult social care sector will have to attract significant numbers from other sectors because it will be less able to rely on “slack” within the labour market (i.e. an abundance of people who want work but have no job or are underemployed) to help fill vacancies. For these reasons, our assumptions, underpinning rates of growth in the care workforce, are necessarily conservative, but plausible based on an analysis of labour market trends and limited data on how the care workforce has evolved over time. In any case, it is worth reiterating that the scenarios are projections of the future and not forecasts.
Modelling the impact of immigration on the social care workforce

We apply the above methods to two English population variants. High migration (which assumes 200,000 net migrants from 2019 onwards and low migration (which assumes 83,500 net migrants from 2019 onwards)\(^7\). The different migration variants lead to different overall population structures for England over the forecast period – notably high migration leads to a larger working age population relative to the older age population. In the high migration variant, there is one older person for every 2.5 people of working age in England by 2037\(^8\). By contrast, in the low migration variant, there is one older person for every 2.4 people of working age by this point – a small but significant difference. Migrants are therefore accounted for as part of the overall population of England. The different migration variants only influence our results in so far as they impact on the country’s population structure – boosting the care workforce relative to the older population. We do not assume that migrants are more or less likely to join the care workforce than anyone else.

Bringing it all together to calculate the care workforce gap

To understand whether the workforce is able to meet demand adequately over future years, we must first define what we mean by adequate. For the sake of simplicity, we assume there is only an adequate supply of workers if the ratio of care workers to those who demand care is consistent with 2015 levels. We then assess the extent to

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**Figure 8:** Old age dependency ratios: high versus low migration

<table>
<thead>
<tr>
<th>Year</th>
<th>Low migration</th>
<th>High migration</th>
</tr>
</thead>
<tbody>
<tr>
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<td>4.0</td>
<td>3.5</td>
</tr>
<tr>
<td>2018</td>
<td>3.5</td>
<td>3.0</td>
</tr>
<tr>
<td>2021</td>
<td>3.0</td>
<td>2.5</td>
</tr>
<tr>
<td>2024</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>2027</td>
<td>2.0</td>
<td>1.5</td>
</tr>
<tr>
<td>2030</td>
<td>1.5</td>
<td>1.0</td>
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<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td>2036</td>
<td>0.5</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Source: ONS and author’s calculations

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Moved to care: the impact of migration on the adult social care workforce
which the future projected supply of workers meets or exceeds this ratio, and where it doesn’t we calculate how many additional workers would be needed to meet the ratio. For instance, in 2015 there were approximately 6.8 people over the age of 65, for every care worker. If in 2016 there were projected to be 5.8 care workers for all those aged over 65, we would then calculate how many more workers we would need to boost the ratio back up to 6.8. This is the final part of the jigsaw which allows us to calculate projected workforce gaps up to 2037, accounting for rising or falling sector attractiveness and high or low migration – both of which can be addressed, at least in part, through government policy.

**Results of the modelling**

1 **Low migration, sector unattractive**

To model a world where the sector becomes gradually less attractive to the workforce, we assume the proportion of the current working age population who work in the sector falls gradually every year for the next twenty years. In addition, we assume that the English population (this includes migrants and non-migrants residing in England) rises in line with the ONS’ low migration scenario, where the number of net migrants falls to fewer than 100,000 per annum.

**Outcomes by 2037:** By the end of the projected period, the adult social care workforce will have a gap of 1.05 million workers – this means that the workforce would need to attract an additional 1.05 million additional workers in order for supply to meet demand as it did in 2015.

2 **Sector unattractive, high migration**

Policymakers try to offset care workforce shortages by relaxing migration targets. As such, we assume that the workforce becomes less attractive as per the first scenario, but that the population rises in line with the ONS’ high migration scenario – with net migration reaching 200,000 per annum.

**Outcomes by 2037:** In this scenario, increased net migration makes a small difference to the overall gap. By 2037, the gap is 50,000 workers lower than it was in our most pessimistic scenario, but still stands at one million workers. Higher net migration, therefore, makes a difference at the margin but a large supply gap remains.

3 **Sector attractive, low migration**

Rather than relying on migration, the government and other stakeholders try to make the sector more attractive to the UK labour market. As a result, we assume the proportion of current working age residents who work in the adult social care sector gradually rises up to 2037. In addition, we assume that the English population rises (migrants plus non-migrants) in line with the ONS’ low migration scenario, where the number of net migrants falls to fewer than 100,000 per annum.

**Outcomes by 2037:** In this scenario, the workforce gap is significantly reduced relative to the previous scenarios, reaching 433,000 by the end of the projected period. The gradual rise in the attractiveness of the sector therefore helps to reduce the gap significantly, though it is not enough to close it altogether.
Finally, the government and other stakeholders take measures to boost the attractiveness of the sector and facilitate greater migration. As such, we assume that the workforce becomes gradually more attractive up to 2037. We also assume that the English population (this includes both migrants and non-migrants) rises in line with the high migration scenario – over 200,000 net migrants per annum.

Outcomes by 2037: In this scenario, the workforce gap is smaller than in any of the other scenarios – 353,000 by the end of the projected period. This is significantly smaller than the gaps outlined in all of the other scenarios, though still not enough to close the care workforce gap altogether. The effect of higher net migration is to reduce the gap by 80,000 by the end of the projected period.

2037 feels like a long time away, but workforce gaps do not just appear in 2037 within our projections, but grow cumulatively over the period. Figure 9 shows how the workforce gaps evolve, growing particularly rapidly from the 2020s onwards as the baby boomers reach their mid-60s and beyond, and growth in our working age population starts to slow. This highlights the point that this is not just some far off problem but something that we need to deal with now. For instance, in the unattractive sector, low migration scenario, the workforce gap will already grow to 200,000 by the end of this parliament. This figure equates to 14% of today’s care workforce.
What level of growth in the workforce is required to close the gap altogether?

In order to close the gap over the entire period, the proportion of working age people working in the adult social care sector needs to rise from around 4% today, to around 6% by 2037 – which contrasts with the rise from 4% to 5% assumed in the above scenarios. While on paper this may not sound like a significant difference, such a shift is more akin to that experienced by the entire health and social work sector between 1997 and 2014. This sort of shift is not impossible but is likely to depend on the adult social care sector being able to compete with, and attract workers from other large sectors of the economy. Given the care sector’s current reputation for low pay and physically and emotionally demanding work, this is likely to be challenging and will require substantive policy change to secure.

The need to raise attractiveness and rely on migrant workers

While the scenarios are not predictions of the future, they do tell an interesting story. Based on plausible assumptions regarding future care workforce participation and migration, there is only one future whereby the care gap does not grow dramatically out of hand over the next twenty years. This is where all relevant stakeholders are successful at both encouraging more of the working age population to join the care sector and harnessing migrant workers. Anything less than this will result in a sector that fails to meet future demand for care.

And even in the most optimistic scenario, there is still a significant workforce gap by 2037. Our modelling therefore implies that policymakers may need to have a fundamental rethink about future delivery models for adult social care, to ensure that the sector can effectively compete with and attract labour from other industries to meet the needs of an ageing population. The demographics are such that the UK will need a significant increase in care workers (wherever their country of origin). In the absence of substantive policy change, unpaid carers will be required to close the care gap but this will have ramifications for the quality of care and the wider economy. In the next section, we review models of care delivery in other advanced nations, including the roles that migrants and unpaid carers play within different settings.

A quick recap

In summary, to ensure that the future level of services in the adult social care sector remains at least as good as it is today, we need changes in policy and a dramatic shift in the perception of working in care. Indeed, neither greater migration nor a modest increase in the attractiveness of the adult social care sector will be enough to guarantee a sufficiently large workforce. Even in our most optimistic scenario, the sector will have 353,000 fewer care workers, relative to demand, by 2037 than it has today. To meet the needs of an ageing population, the proportion of people working in the adult social care sector needs to rise from around 4% today, to around 6% by 2037.
Alternative policy options: evidence from other advanced economies

Key points

- Italy has a familial approach to long-term care, with older people being looked after in their homes or in their relatives’ homes. Increasing demand for care, combined with the ease with which many migrants can work irregular hours, means that many families have adopted a ‘migrant in the family model,’ with migrants working as live-in carers, often on an irregular basis.

- Germany has a somewhat restrictive migration system but has, in the past, made amendments to the law to allow migrants to work specifically in the adult social care sector. This means that Germany was, up to a point, able to retain some control of overall migration without it overly affecting the social care sector.

- The Netherlands, on the other hand, operates a system of personal budgets, provided by the state, whereby the person in need of care is able to choose to pay a relative or a professional care worker. Many, therefore, choose to go with a relative which some believe explains why only 7% of the care workforce is made up of migrants.

- Canada has a specific scheme for recruiting migrant care workers – the Live-In Caregiver Program (LCP). It allows migrant care workers admission to Canada so long as they meet certain conditions.

- Sweden takes a more open approach to migration than the other countries considered in this chapter as they have no numerical restrictions on migrants. This provides Sweden with much more flexibility in terms of hiring migrant workers to plug care workforce gaps, though it reduces the amount of control that Sweden has of overall migration into the country.

- Based on our analysis of the different social care systems, we reach two general conclusions:
  - Migrant workers feature prominently in a number of countries – both in the delivery of professional and “migrant in the family” style delivery of care. Migrants therefore appear to be integral to the delivery of adult social care, irrespective of the overarching delivery model.
  - A greater reliance on family carers may help to alleviate some workforce pressures, but such a response could have unintended consequences, not least an erosion in the quality and professionalism of care provision. In addition, those who cannot rely on care from family or friends may lose out altogether.
About this chapter

This chapter explores what a selection of other advanced countries have done in relation to migration policy and adult social care, and whether the UK might be able to learn any lessons from these examples. In this regard, the following chapter explores developments in Italy, Germany, Canada, the Netherlands, and Sweden. These countries are chosen because they represent a diverse mix of approaches to funding and providing long-term care in other high-income countries.

Different approaches to care

Across European societies there is substantial variation in the way long-term care is approached. In countries such as Italy, Spain, and Croatia, long-term care for older people is seen as a familial responsibility, rather than a profession with paid employees, and there is little state funding for care. In recent years, the increased demand for long-term care, coupled with limited formal paid provision, has led to a ‘migrant in the family’ model where migrants work in family homes, often informally. By contrast, in other countries, including Denmark and the Netherlands, the state bears the responsibility for older people and others who are in serious need of long-term care. In these countries, citizens have a right to professional formal care. When migrant care workers are employed, it is formally, although they are often employed in positions which require low levels of formal qualification.

Funding arrangements for care also differ across Europe. Cash benefit schemes – where individuals are given a cash sum to spend on care as they see fit – are in use in a range of countries. In Spain and Italy, they account for between a half and three-fifths of long-term care expenditure and in the Netherlands, individuals are given control over their care through personal budgets. In Hungary, cash benefits are provided to family members who take on caring roles. By contrast, in other countries, such as Denmark, there are no major cash benefits and state support for care is provided in kind (i.e. services).

In many countries, policies surrounding migrant care workers are simply part of wider immigration legislation and procedures. In the rest of this chapter, we explore instances where there are specific policy measures regarding migrant care workers, both in Europe and in North America. We then investigate how these policies relate to their respective national care settings and draw some possible lessons for the English social care sector.

Italy

In Italy, state support for long-term care is limited and traditionally it has been provided by families or voluntary organisations. While migrant care workers have worked in Italian homes for decades, in recent years their number has greatly increased and their role has changed, evolving from “home helps” – such as maids and cleaners – into personal care assistants. Among single people over the age of 75, 7% employ a foreign domestic worker and 2.6% employ a live-in foreign domestic worker.
A substantial number of domestic workers are employed irregularly – i.e. after their legal right to work in the country has ended. A 2007 survey found that most migrant domestic workers actually entered the country on a temporary tourist or student visa, of which the majority had then lived in Italy irregularly for a time and a quarter were still residing irregularly\(^90\).

It has been noted that migrant care workers work longer hours, are more likely to live-in with their employer and earn less than their Italian counterparts\(^91\), which perhaps explains their appeal to the older people and families that employ them. The cost of care is particularly pertinent due to the low level of government funding to those with care needs. Government support is too low to buy services on the formal market, but if supplemented with a pension or family support, individuals in need of care could cover the cost of a migrant worker. Furthermore, the fact that it is relatively easy to work irregularly in Italy\(^92\) makes it easier to hire a ‘migrant in the family’ and once it became clear that many families were hiring migrant care workers, the Italian government initiated programmes of “regularisation” in 2002 and 2009\(^93\) to bring migrant care workers into the formal labour market.

There have also been work permits issued to migrant care workers. Thus although there has been no specific long-term government strategy to facilitate the growth of a migrant care workforce, ad-hoc policy developments and the wider labour market environment, combined with a familial approach to care, have meant that migrant care workers continue to play a dominant role in providing adult social care in Italy.

**Germany**

Germany has a well-developed system of long-term care insurance. All working people must have some form of insurance and they can choose to use a government programme or a private provider. When drawing on their insurance, individuals can choose either cash benefits or benefits in kind. However, the insurance only covers home care. If individuals require institutional care they must pay for this separately (and only 3.5% of those over 40 have a long-term care insurance plan which would cover them in this instance).

The system of social insurance in Germany is predicated on the contribution of familial carers and cash benefits. This can be used to pay family members for care, which is ‘predominantly chosen over home care agency services’\(^94\). Over half of older people with care needs are looked after by family members alone, with no professional help\(^95\). Family care is so ingrained in the German care system that those without children have to pay 0.25% more insurance contributions than those with children\(^96\).

However as long-term care needs increase, the potential for family members to coordinate care becomes more limited, leaving a gap for home care to be filled by migrant care workers. Indeed a 2011 report noted that ‘the German care system has a comparatively small number of home care staff, which means an unfavourable ratio of older care-dependent people to such staff. The lack of skilled workers, the huge staff turnover and the short period of time home care nurses pursue their profession are phenomena that reveal the problems inherent in care services.’\(^97\)
In the past, Germany has used targeted migration policies to attempt to plug workforce gaps in the care sector, although with limited success. For example, when many Eastern European countries joined the EU in 2004 and 2007, there were initially limits to labour mobility from these countries to other European countries. But during this period, Germany ran a scheme for recruiting migrant social care workers from these regions. Individuals, who required a certain level of care, were allowed to recruit nationals from Bulgaria, Czech Republic, Hungary, Poland, Romania, Slovakia and Slovenia. The employment was required to be full time, could not last more than three years and their work was restricted to housework and basic care. Employers had to make social security contributions, pay for health and accident insurance and pay a wage in line with local tariffs. The scheme was not particularly well used, with fewer than 2,500 placements in 2006. By contrast, around the same time it was estimated that there were close to 100,000 irregular migrant care workers in Germany. Low take-up of the scheme has been attributed to the higher cost of such workers in comparison to irregular migrant workers, the fact they were not allowed to work long hours, and that they could not offer personal or nursing care.

**Netherlands**

The Netherlands also has a universal and compulsory social care insurance scheme, administered by private insurance companies, which individuals pay into both through an income-related premium deducted from their wages and an employer contribution. Unlike in Germany, the scheme covers both home care and residential care, but there is still the option to take benefits in cash or in kind. If taken in cash, individuals receive a personal budget which they can use to pay family members for care. It is estimated that only around 8% of long-term care workers in the Netherlands are first-generation migrants and the inflow of migrant workers into the Dutch care sector is significantly less than that to other areas of the Dutch economy. Some have argued that this is because many older people in the Netherlands opt to take their care benefits in cash and use their personal budget to pay family members for their care. Yet, it is thought that most recipients of personal budgets simply spend the money provided by the scheme and buy less care than their assessed need. This example shows how the model of paying for care directly affects the demand for migrant labour within the adult social care sector as well as limiting the demand for professional care workers. However, as with the German example, reliance on family to provide care limits the level of professional care being provided, which can reduce quality.
Sweden

The Swedish government provides generous, universal and comprehensive social care to its citizens. The system covers both home and residential care. Demand for care workers is partially met by migrant workers; indeed Sweden’s approach to labour immigration is quite different from that of other European countries. Elsewhere in Europe, non-EU migrants face quota systems, a points-based system, or an immigration system that ties entry to the qualifications or skills of applicants. However in Sweden, there are no such restrictions on migrant labour. An individual from outside the EU will be granted a temporary work permit so long as the position of work they are applying for has been posted on the EURES network – the European job mobility portal – for a minimum of 10 days and their salary and working conditions are appropriate for the sector and position. This gives Sweden much more flexibility in hiring migrant care workers than other countries in Europe and in 2009, over 20% of the care workforce were foreign born, of which around 20% arrived to the country as asylum seekers. Swedish provision of social care is seen as a “best practice example by international standards, principally because of the generosity of its coverage and low user charges”. The extent to which Sweden’s open migration policies contribute towards this is impossible to determine without better evidence. But it is worth pointing out that the Swedish government spends a higher proportion of GDP on social care than any other OECD country except the Netherlands.

Canada

Long-term care provision varies across provinces and territories. Some, such as Nova Scotia, require individuals to pay the full cost of residential care if they are able to afford it; while others, such as British Columbia, offer more generous support for residential care costs. Home care is provided according to need and is generally free of charge, although individuals must pay for homemaking services and personal care.

Canada has a specific scheme for recruiting migrant care workers – the Live-In Caregiver Program (LCP). It allows migrant care workers admission to Canada so long as they have a written contract with a Canadian employer, the equivalent Canadian secondary school education, at least six months’ training or a year of full-time paid work experience in the past three years, good knowledge of English or French, and a work permit. Given the need for a job offer before they can enter the country, migration through this scheme is employer driven. The admission is on a temporary basis but care workers can later apply to become permanent Canadian residents. Between 2011 and 2013, about 4,500 people applied for permanent residence each year through the Caregiver Program. The scheme is used for recruiting live-in care workers, rather than workers for care homes. However as of 2014, carers have the option to live outside their employer’s home. It is estimated that around a fifth of the health and social care workforce in Canada were born abroad.
Towards some general lessons

Other developed nations operate significantly different models of paying and delivering care from England. Germany and the Netherlands rely on the family to provide care in the main, with cheap migrant labour filling remaining gaps – particularly in Germany. A greater reliance on family carers may help to alleviate some of the workforce pressures currently facing the English social care sector, but such a response to the care crisis could have unintended consequences, not least an erosion in the quality and professionalism of care provision. In addition, those who cannot rely on care from family or friends may lose out altogether.

Alternative approaches include a high reliance on live-in migrant care workers like in Italy, though this system is far from ideal, given the lack of employment rights for irregular care workers, and the fact that they are paid ‘out of pocket’. Sweden, on the other hand, has an open door migration policy, which has resulted in similarly high proportions of migrants, as part of the care workforce, as in England. Whether it is possible to replicate the Swedish approach within a UK political context is highly debatable, and in any case, as we showed in the previous chapter, migration alone will not solve the impending care workforce crisis in England. Sweden, however, has been described as an example of best practice with regard to care provision, but this comes at a cost – Sweden spends 3.6% of GDP per annum on long-term care by comparison to an OECD average of 1.6%. The UK is estimated to spend around 1.1% of GDP per annum on long-term care.

Finally, Canada’s approach may be somewhat more politically feasible, with legislation enabling employers to take on migrants as care workers provided they fulfil certain criteria, and with the opportunity of permanent residency.

A quick recap

In summary, no country has a perfect model of care delivery, but what is striking is that migrant workers feature prominently in a number of countries – both in the delivery of professional and “migrant in the family” style delivery of care. Migrants therefore appear to be integral to the delivery of adult social care irrespective of the overarching delivery model. Some countries have also made explicit provisions for enabling entry into the professional care workforce for migrant workers.
Conclusion and recommendations: addressing the perfect storm

“I am not on benefits. I am working, paying all of my bills by myself. I don’t see why I should not be allowed to stay in the country.”

Female, 51, from Nigeria, works in residential care

The adult social care sector faces a perfect storm. On the one hand, the sector has faced an extended period of underfunding – crippling budget cuts at a time when the population is ageing and when the care sector is already held in relatively low esteem. This has made it harder for the sector to provide care for those who need it and to recruit UK born workers who perceive the sector to be low status, “feminine” work.

For their part, care providers, who have been hit by funding cuts over many years, continue to view migrant workers as a vital part of their workforce. It is worth reiterating that one in five care workers in England were born outside the UK and that this rises to three in five within London. Migrant care workers are seen to be relatively cheap for their skill sets and have lower turnover rates than their UK born counterparts.

But times are changing. While care providers may have been able to rely on migrant labour in the past to fill gaps in the workforce, current and anticipated migration policy is putting this at risk. Migration policy has become increasingly restrictive to non-EU migrants, who make up the largest proportion of migrants working in the adult social care sector. Not only will anticipated policy make it almost impossible for care providers to recruit from non-EU countries, but it may also result in some current non-EU born care workers having to leave the sector altogether. While some care providers may be able to recruit from the EU in the short term to fill any workforce gaps, there is significant uncertainty about how the UK’s ongoing negotiations and eventual referendum on EU membership will affect EU migration over the medium to longer term.

With the population continuing to age, demand for adult social care will rise. But the UK’s working age population will not rise as quickly as the older population, making it even harder for the workforce to grow in line with demand. Something’s got to give. Key stakeholders need to work together in order to make the care workforce more attractive to UK residents and find ways to enable
migrants to continue to enter the sector, or the sector will become crippled by a lack of workers to meet demand. Those in need of care will have to fall back on family members where they are able to or, where such support is not possible, they may have to go it alone. As the examples from other countries have demonstrated, reliance on family support is no silver bullet and could risk an erosion in the quality of care provided.

In addition, the responsibility of providing unpaid care can have a significant effect on the health and wellbeing of unpaid carers. This also has implications for overall employment levels, with those providing care often reducing their hours in work or potentially leaving the workforce altogether to care for loved ones. And for those who go it alone, there are clear risks for the NHS in terms of emergency admissions as well as delayed discharge from hospital. If this is the future, the care crisis has only just begun and it will have dire implications for those needing care, their family members and the wider economy.

**Recommendations: What can we do about it?**

The following set of recommendations are intended to address both the time-sensitive challenges facing the adult social care workforce and sector, as well as the bigger long-term strategic challenges which are likely to take longer to resolve.

**Migration is part of the solution in the short term**

Current migration policy is likely to continue to prevent some migrants from entering the care sector. But as this report has shown, migration will have to play a critical role in filling the care workforce jobs of the future. Put simply, in a situation where the care sector can no longer rely on migrants to plug the gap, there will be a smaller number of care workers to look after the UK’s older population, potentially eroding the amount and quality of care being received. While, to some extent, the sector may be able to rely on EU migrant labour to fill some of the workforce gaps as non-EU migration policy becomes more restrictive, there is no certainty that this strategy will be successful. Migration from all parts of the world is not simply a tap that can be turned off and on at will. The least risky approach is to offer multiple avenues through which to attract workers into the sector given the scale of the workforce challenge – avenues for those born in the UK, the EU and further afield. In this regard, we recommend the following short-term measures:

- Skilled care worker roles, including senior care worker should be included in the current Migration Advisory Committee’s Tier 2 Shortage Occupation List. While we note the recent announcement that nurses will be temporarily added to the Shortage Occupation List, we think there is a good case for nurses to be permanently added to this list in future.
• Non-EU migrant workers who have entered the care sector through Tier 2 should be exempt from the £35,000 income threshold. The alternative approach is to lower the income threshold for the sector, but this is still likely to result in some workers falling below the threshold despite being high skilled and providing socially useful roles.

• Because the Shortage List only includes skilled migrant labour, there is no equivalent path for low skilled non-EU migrant labour despite the reliance of the care sector on it. We therefore recommend Tier 3, which is for low skilled workers filling temporary labour shortages, be opened up in order to help the sector meet immediate staffing needs.

The care sector must become more attractive over the longer term for UK born workers

This report has shown that migration will not be a silver bullet to solving the long-term workforce challenges facing the care sector. Even if we assume high migration levels over the next twenty years, this will not be enough to plug the care workforce gap. Critically, we must find ways to encourage more UK born workers into the sector as well as migrant labour. Government and other stakeholders, at the national and local level, need to find ways to make the care sector more attractive for groups who are currently under-represented in the workforce. In this regard, there needs to be a national framework led by central government to support the needs of the adult social care workforce.

This must be complemented by local action to ensure that there is a match between workforce supply and demand, drawing on knowledge of local labour markets. Local Enterprise Partnerships could take on a key role in promoting partnerships between schools, colleges, local Job Centre Plus advisers and employers to increase the numbers going into care work in areas where it is most needed.

In addition, this report calls for three specific measures to attract young, well-educated adults, older workers and men into the sector:

• **Step up to social care:** It is important that jobs in the care sector are perceived to be high status. Step up to social care would help do just that. It would be an intensive programme to equip the future generation of social care workers with the right mix of knowledge and practical skills to drive the sector forward. Those enrolled on the programme would have the chance to obtain a Postgraduate Diploma in Social Care with the aim of gaining management positions within the sector on completion.

• **Care-prentices:** The importance of stimulating longer and fuller working lives is being increasingly discussed and emphasised in policy circles. This report argues that working in the care sector can be one way to facilitate this. Offering care-prentices – structured on the job training with formal mentoring and support – for those aged over 50 and out of work, or simply looking for a career change, could be one way to entice older workers into the sector.
A national campaign to attract more male care workers:

With men accounting for just one in five care workers, something dramatic needs to be done to attract more men into the sector. In this context, government and industry could work together to deliver a joint campaign calling for more male care workers, supported by examples of men who are currently working in important and fulfilling roles in the sector. Some providers are already doing this, but clearly pooling the resources of many different providers in the sector could lead to a larger and more effective campaign.

The sector needs more funding to support better pay and working conditions

Long-term underfunding has left the sector on its knees. The current funding situation is unsustainable, and the government must find ways to direct more money into the sector. The negative perception of working in social care is not just the fault of long-term underfunding. A number of other factors are also at play, including care work being seen as “feminine work”, the often strenuous nature of the job and the perceived lack of opportunities for training and career progression. But underfunding contributes to many of these issues by limiting the resources available for providers to invest in their staff and recruitment. While the Living Wage is to be welcomed, without additional funding being directed into the adult social care sector, some providers will struggle to pay their staff the new rate.

And with all sectors having to meet the new Living Wage, it is not as though the care sector will suddenly improve its position when competing with other industries to attract workers. Given that the government is asking all unprotected departments (which includes the department that funds adult social care) to model the impact of 25-40% spending cuts over this parliament, the prospect of more underfunding for the social care sector is looming large.

To help improve the standing of the adult social care sector over the long run, more funding for the sector is required. Therefore, we think the government should do the following:

- Capitalise on current momentum and introduce a single ring-fenced budget for health and social care nationwide to support integration of services and reduce the current disparity between health spending, on the one hand, and social care spending on the other. With this option, there is, of course, a risk that both health and care would end up fighting over one increasingly limited pot, which would be detrimental to both services. For this reason, integration must be accompanied by a single budget that rises in line with the nation’s combined health and social care needs.

- In order to help determine the future level of spending required, the government should establish an independent committee to monitor current and projected health and social care needs and from that to recommend future national funding levels. The government would of course have ultimate say as to whether or not it takes forward those recommendations, as well as the means with which it funds the single ring-fenced budget.
Establishing such a committee would provide some much needed transparency to the issue of health and social care funding, which is currently a largely misunderstood and complex area.

**Better support for unpaid carers**

Future care workforce challenges may mean that there will be a continued or potentially greater reliance on unpaid carers to support the needs of older people. Indeed, even if the care workforce rises in line with demand, there will remain individuals who choose to care for loved ones rather than relying on professional care workers. While we would argue that unpaid care should not replace professional care, there is a clear case for providing better support for unpaid carers to alleviate the financial, mental and physical costs that they can face. In this regard, we think developments are needed in three areas:

- **Increased employer support for those providing unpaid care:** Legislation requires that employers must take note of requests from staff for flexible working but they are under no obligation to grant it. There may be a case to consider strengthening the law to make it harder for employers to refuse such requests, where people are seeking to juggle work and providing care (as well as juggling work and health problems). But in addition, policymakers could also think about carrots as well as sticks to support employers who embrace flexible working – such as tax incentives that support small employers.

- **The social security system should better recognise the work that unpaid carers provide:** The government should use its planned carers strategy to review how the social security system recognises the contribution of carers. As an example, the government could examine the rate Carers Allowance is set at and how rules on entitlement could be simplified to increase uptake of the benefit. Currently set at £62.10 per week for those providing at least 35 hours of care a week, this amounts to under £2 per hour of care provided.

- **Improved access to professional and emotional support:** As examples from other countries have shown, unpaid carers are not professional care workers. A higher reliance on unpaid care giving could potentially erode levels of quality as well as having detrimental health and wellbeing impacts on the carer. The Department of Health should consider the case for a wider duty on the NHS to identify carers and refer them to appropriate support, for example, to receive respite and replacement care. Such support already exists in some circumstances, but if we are to become more reliant on unpaid carers in the future, such networks will need to be enhanced and expanded in the near future.
A final recap

If the goal is to recommend a course of action to ensure the social care sector is well staffed over future years, public policy must encourage both more UK born residents into the care sector and facilitate a greater number of migrants to join the workforce. Anything less than this will result in a sector that fails to meet future demand for care. To help make this happen, this report argues for specific exemptions for non-EU migrant workers, innovative campaigns to entice under-represented groups into the care workforce and greater funding for the sector, supported by the creation of an independent committee that would outline the future funding needs of the population. Finally, we have argued for greater support for unpaid carers who face considerable financial, mental and physical pressures. The stakes are high but not insurmountable.
Appendix: Definitions

Job roles subcategories

Manager/Supervisor: senior management; middle management; first line manager; registered manager; supervisors, managers and staff care-related but not care-providing.

Professional: social worker; occupational therapist; registered nurse; safeguarding and reviewing officer; allied health professional; teacher (qualified).

Direct care: senior care worker; personal assistant; care worker; community support and outreach work; employment support; advice guidance and advocacy; educational support; youth offending support; counsellor; nursery nurse; childcare worker or childcare assistant; education assistant; technician; other job roles directly involved in providing care.

Other: occupational therapist assistant; administrative/office staff not providing care; ancillary staff not providing care; activities worker coordinator; other job roles not directly involved in providing care.

Qualifications

The Qualifications and Credit Framework (QCF) recognises nine levels of skill, starting at entry level and rising to level 8. These skill levels cover both vocational and academic qualifications.

What do qualifications mean (with some examples specifically from the care sector)\(^{111}\)?

- **Entry levels 1, 2, 3**: Limited knowledge and skills.
- **Level 1**: equivalent to GCSE grades D-G; Basic knowledge and skills, can work under direct supervision in a structured setting. Examples: Level 1 Award in Preparing to Work in Adult Social Care.
- **Level 2**: equivalent to GCSE grades A*-C; Good knowledge of work area, can perform tasks independently with some supervision – **Level 2 is the baseline skills level for occupational competence.** Examples: Level 2 Diploma in Health and Social Care, Intermediate Apprenticeship in Health and Social Care.
- **Level 3**: equivalent to GCE AS/A Levels; Detailed knowledge and skills, can take responsibility for work – Level 3 skills are associated with supervision. Examples: Level 3 Diploma in Health and Social Care, Advanced Apprenticeship in Health and Social Care.
- **Level 4 to 8**: Knowledge and skills suitable for technical, professional and management-level work – with expertise increasing at each level. Examples: Level 5 Diploma in Leadership for Health and Social Care and Children and Young People’s Services, Higher Apprenticeship in Health and Social Care – Care Leadership and Management (England).
1 For more details see: OBR (2015) Fiscal Sustainability Report
2 ONS Population Projections, 2012 based, Principal Projection
3 Within this report when we refer to Europe and the EU we mean the 28 member states of the European Union plus 3 members of the European Free Trade Association – Iceland, Liechtenstein and Norway. Technically this is the European Economic Area, but for the sake of simplicity we refer to it as the EU and Europe throughout the report.
5 ADASS (2015) ADASS Budget Survey 2015
7 In 2013/14, 36% of care home residents were wholly funded by the local authority, 13% part funded by local authority and part self-funded and 44% were self-funded. LaingBuisson (2014) Care of Older People, UK Market Report, 26th edition, 2013/14
11 Author’s calculation combining ELSA data (2012/13) and ONS population data
12 Ibid.
15 Resolution Foundation (2013). Does it Pay to Care?
16 Ibid
21 http://www.workpermit.com/uk/uk-immigration-tier-system/tier-3-unskilled-migration.htm
24 Migration Observatory (2015). Skilled migrants and a tight cap. Available at: http://migrationobservatory.ox.ac.uk/commentary/skilled-migrants-and-tight-cap
27 https://www.gov.uk/government/speeches/pm-speech-on-immigration
31 House of Commons Library (2015). Further proposals to restrict migrant’s access to benefits. Available at: http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN07145
32 Ibid.
33 Ibid.
34 The number of jobs is higher than the number of workers because a large number of people hold more than one job.
35 We estimated the total number of workers in each broad sector and job role, by combining our own calculations with those provided by Skills for Care in its latest report.
37 A8 countries are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia
39 Ibid.
40 A level 2 qualification is equivalent to GCSE grades A*-C, such as Level 2 Diploma in Health and Social Care or the Intermediate Apprenticeship in Health and Social Care.
41 The main exception is the role of senior care worker – which also sits under the direct care classification – requiring a higher qualification attainment than Level 2.
42 Our estimates combined with Skills for Care (2014) estimates of the total adult social care workforce.
45 Vacancy rate in adult social care sector was taken from NMDS-SC 2015, National Key Statistics September 2015. Vacancy rate for the UK as a whole was taken from ONS (2015) Labour Market Statistics Database.
47 Ibid.
50 Kingsmill, D. (2014) The Kingsmill Review: Taking Care An independent report into working conditions in the Care Sector
53 Ibid.
56 Kingsmill (2014)
57 Skills for Care (2013). Why are some employers more successful than others in retaining their workforce?
62 Level 4 qualifications include: Certificate of higher education, Key Skills level 4, NVQ level 4 BTEC Professional award, certificate and diploma level 4 Certificate of higher education HNC
63 Green et al 2014
66 The Kingsmill Review (2014) Taking Care: An independent report into working conditions in the Care Sector
67 Manthorpe et al, 2010
66 The Kingsmill Review (2014) Taking Care: An independent report into working conditions in the Care Sector
67 Manthorpe et al, 2010
70 Ibid
73 Manthorpe et al. 2010
74 Ibid
75 Ibid
76 Cangiano and Shutes (2010)
78 Skills for Care, various care workforce reports. It is worth noticing that numbers of jobs actually increased over this period.
79 Both ONS population projection variants, along with a host of others can be downloaded from the ONS website: http://www.ons.gov.uk/ons/index.html. It should be noted that the high migration assumption is still lower than net migration in 2014-15 (over 300,000 net migrants during this period).
80 Old age dependency ratios calculated by: total number aged 15-64/total number aged over 65.
81 The choice of the trend is arbitrary but is aimed at ensuring that the fall happens gradually over time. It is based on the trend % of working age people in the health and social care sector over the last 3 years. Ultimately the assumptions underpinning the modelling are chosen to be illustrative and plausible but are not a prediction of the future.
82 The term irregular migrant refers to actions that directly concern the migrants themselves, as well as third parties, who help or arrange the ‘deception’ of UK authorities. Irregular immigration status can also arise from legal entry and illegal overstaying of a time limited visa. (source: Migration Observatory)
84 Ibid
85 Ibid
86 Although eligibility for these has been cut back since January 2015 in an attempt to curtail rising costs to government.
87 Van Hooren, F.J. (2011), “Caring migrants in European welfare regimes: The policies and practice of migrant labour filling the gaps in social care”, European University Institute, Firenze
88 Ibid
89 Ibid
91 Hooren (2011)
92 Ibid
93 Ibid
94 OECD (2011) Help Wanted? Providing and Paying for Long Term Care, Chapter 4 – Policies to Support Family Carers


97 A. Angermann (2011) Eldercare Services in Europe – Home Care, Family Support and Domestic Services for Older People, Observatory for Sociopolitical Developments in Europe


99 Ibid


102 Van Hooren (2011)


104 Ibid


106 Robertson, Gregory and Jabbal (2014)

107 Commission on the Future of health and social care in England (2014) the social care and health systems of nine countries

108 OECD (2005) Long Term Care for Older People, The OECD Health Project


113 The UK figures are from the OBR so not directly comparable with the OECD figures.

114 It is estimated that around 6-7% of people in England who take early retirement do so because of the ill health of a friend or loved one. For more details see : Franklin et al. (2014), Illuminating the employment challenges of the over 50s, report for LIC-UK and BITC

115 Skills for Care, practical guide http://www.skillsforcare.org.uk/Skills/Core%20skills/ Core-skills.aspx.
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Mario Ambrosi, Head of Policy, Anchor
Jane Ashcroft, CEO, Anchor
David Griffiths, Programme Head, Analysis, Skills for Care
Shereen Hussein, Principal Research Fellow, KCL
John Kennedy, Director of Care Services, JRF

Jill Manthorpe, Director, the Social Care Workforce Research Unit, KCL
Carys Roberts, Researcher – Social Policy, IPPR
Isabel Shutes, Assistant Professor of Social Policy, LSE
Jennifer Smith, Associate Professor of Economics, Warwick University
Deborah Sturdy, Care England Nurse Adviser
Madeleine Sumption, Director of The Migration Observatory

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Founded over 150 years ago, Independent Age is a growing charity helping older people across the UK and Ireland through the ‘ABC’ of advice, befriending and campaigning. We offer a national telephone and email advice service focusing on social care, welfare benefits and befriending services, which is supported by a wide range of printed guides and factsheets. This is integrated with on-the-ground local support, provided by a network of over 1,500 volunteers offering one-to-one and group befriending. Independent Age is a founder member of the Campaign to End Loneliness.

For more information, visit our website at www.independentage.org

The International Longevity Centre-UK (ILC-UK) is an independent, non-partisan think tank dedicated to addressing issues of longevity, ageing and population change. It develops ideas, undertakes research and creates a forum for debate.

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