Chapter 5

The English social care workforce: the vexed question of low wages and stress[1]

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Abstract

Over the past decades the English adult social care system has seen a set of policy reforms combined with funding cuts and austerity measures. This chapter utilizes secondary and primary data sources to investigate the current state of the English social care workforce with a particular focus on the increasing role of migrants; persistent low wages and job related stress. The findings highlight the continued role of migrants in the sector with a clear shift in their profile that is consistent with the direction of the UK immigration policies. From 2013 migrants joining the care sector from Bulgaria and Romania alone have exceeded all other migrants entering the sector. The analysis indicates the persistent low wages in the sector, which are facilitated by a number of factors including austerity measures and the increasing role of the private sector and outsourcing of services. The nature of care work combined with difficult working conditions created various situations where individual workers felt a considerable level of stress. The latter is likely to impact not only on workers' ability to complete their work to the highest quality but also has a potential negative impact on their own well-being and increases the likelihood of job quitting.

Introduction

The UK developed its modern welfare state after the Second World War (Esping-Andersen, 1999); compared to other European countries it is relatively more complex and much less universal, particularly when compared to Scandinavian countries. In England, the largest country in the UK, social care is funded through both public and private funds. The state only provides services to those deemed to be unable to meet the cost of care themselves, that is through means-tested assessment. This is in sharp contrast with health services (National Health Service [NHS]), which are free and universal in coverage to all British and European Economic Area (EU plus Norway, Iceland and Liechtenstein) nationals. It is noticeable that in England, the gap between health and social care provision is greater for individuals with higher incomes who often have to pay their full costs for residential care (Roberston, Gregory and Jabbal, 2014). There are no exact figures on the percentage of publically funded social care provision in England, however, there is evidence of a sharp decline in publically funded care services for adults and older people since 2009 (Humphries et , 2016).

Reducing social care state spending has been a policy adopted by successive UK governments with the rationale of coping with government deficits in the aftermath of the financial crisis in 2008. In the two or three decades before the financial crisis, many welfare states in Europe were going through processes that can be described generically as 'marketization', which could be defined as the measures by which the government authorises, supports or enforces the introduction of markets to be responsible for functions previously carried out, at least in part, by the state. The UK was one of the first European countries to adopt this approach to welfare services, starting this process during the Thatcher government years in 1979–1983. Later on, the personalization agenda (since 2007) came into effect and was regarded as *'a cornerstone of the modernisation of public services'* (Department of Health [DoH], 2006). The ethos of personalization is regarded by the DoH as a means of enhancing service users' choice and control regardless of whether they are funded directly by the state or not. Further,

personal budgets (a key component of personalization) later became a 'mainstream' part of care provision, the Care Act (2014) strengthening this policy through its Statutory Guidance:

> Everyone whose needs are met by the local authority … **must** receive a personal budget as part of the care and support plan, or support plan (DoH, 2014, 152 Emphasis in original*)*.

Some argue that the personalization agenda has assisted the progression of the marketization process and shifted some of the state's responsibilities onto individuals (Christensen and Pilling, 2014; Ferguson, 2007). Through the personalization agenda individuals judged to be eligible to receive state support were given control of their own publically-funded budgets, through personal budgets including, if they wished, direct payments (cash-for-care), with which to purchase for themselves the services they chose to use. The availability of personal budgets allowed users to buy their care from a wide range of providers including private (for-profit) organizations. Marketization has thus increased the role of the private sector through various channels, as outsourced providers who compete for local authority funded care packages and as responders to a larger than previously pool of 'clients' with purchasing power (self-funders and those in receipt of personal budgets) (Brennan et al, 2012).

The increased role of the private sector is perceived to have several implications on the social care workforce including the levels of wages, the organization of work and contractual arrangements. This chapter provides detailed analysis of the work structure, wages and the role of gender and migration in the social care sector in England where marketization and personalization form key pillars of social care provision for adults and older people. The analysis is based on empirical studies on the English social care workforce spanning from 2010 to 2016. The chapter starts by providing an overview of the organization of social care

in England and the characteristics of its workforce. It then provides detailed analysis of the extent of and perceived reasons for poverty-pay in the sector. Primarily quantitative and qualitative data obtained from frontline care workers, employers and service users are analysed to further understand the reasons behind persistent low wages in the sector. I then provide evidence of unresolved job stress in the care sector utilising the Karasek Control-Demand model and explore subsequent moral distress among social care workers (Karasek, 1998a).

Data and methods

The findings draw on two research projects: secondary analysis of the National Minimum Dataset for Social Care (NMDS-SC) and the Longitudinal Care Work Study (LoCS), both funded by the English Department of Health. We specifically draw on the analysis of the NMDS-SC, which is recognized as the main source of workforce information for the long-term care (LTC) sector in England. There is no sampling frame for the data, rather there is an attempt to collect information from all care providers of older people and adults, completion being encouraged by incentives of training funds offered to care providers; it is assumed the sample is random for the most part.

The LoCS study adopts a longitudinal design aiming to achieve a locally representative sample of LTC workers in four different parts of England across the statutory, voluntary and private sectors. Nested samples of frontline staff and managers were drawn from care providers in these areas. The study gained ethical approval from King's College London and research governance agreement from the four participating local councils. The mixed-method design includes a repeated survey for staff (n=1342) and repeated interviews with

employers/managers, frontline staff and users and carers (n=300). The current analysis uses the first two waves of LoCS (T1: 2010–11 and T2: 2012–13); a third wave of the survey and interviews were being undertaken in 2016. Both the NMDS and LoCS focus on social care for adults and older people in England and the analysis presented here refers to this sector, any reference hereafter to social care will thus refer to the adult and social care sector excluding social care provision for children and young people.

The LoCS survey included the standardized scales of Karasek's Job Content Questionnaire (JCQ). JCQ is a self-completed instrument designed to identify two crucial aspects: job demands – the stressors existing in the work environment; and job decision latitude (control) – the extent to which employees have the potential to control their tasks and conduct throughout the working day (Karasek et al., 1998a). The control-demand (CD) model postulates that job strain is the result of an interaction between demand and control. The JCQ social support scale combines both co-workers' and supervisory support scales. Such support is theorized to moderate or buffer the impact of job-related stress (Karasek et al., 1998b); in particular, individuals in high stressor jobs will have lower psychological strain in the presence of social support. JCQ also includes a separate indicator of job insecurity.

Both quantitative and qualitative data analysis methods were used to investigate trends in the contribution of migrant workers, wages in the sector and stress and job demand. More specifically, the NMDS-SC was used to investigate trends in the contribution of migrant workers to the English social care sector according to nationality. JCQ obtained from LoCS were analysed using difference in means techniques to investigate associations between different elements of JCQ and various individual and work characteristics. In-depth interviews from LoCS were analysed thematically to investigate reasons for low wages and explanatory factors of stress in the sector.

The English social care workforce

The adult social sector is estimated to offer around 1.55 million jobs in England alone; with 1.2 million of these jobs involving hands-on provision of care ('frontline' jobs), spanning domiciliary (42 per cent), residential (43 per cent) and day and community (15 per cent) service types (Skills for Care [SfC], 2016, pp.14–18). These figures include between 110,000 and 160,000 personal assistant jobs in domiciliary care employed by direct payment recipients (service users who receive payments from their local authority to organize and purchase their own care). The latter figures are likely to under-estimate the numbers of those directly employed by service users due to lack of data on this group.

The sector is characterized by persistent high turnover rates (Hussein, Ismail and Manthorpe, 2016a) with the independent sector (including private and voluntary) employing over three quarters of the workforce (SFC, 2016, p.17). Social care provision relies heavily on the human input of the workers, through hands-on support, provision of personal care, practical and emotional support. The workforce is predominantly female – around 83 per cent overall, rising to 85 to 90 per cent of those undertaking direct care-providing jobs. Men account for up to a quarter of the workforce in certain areas, notably day care, support roles and management (Hussein, Ismail and Manthorpe, 2016b). While women constitute the vast majority of this workforce, men remain significantly over-represented in managerial and supervisory roles, which have better wages and job conditions (Hussein and Manthorpe, 2014). However, not all men enjoy these advantages where ethnic group and nationality interact with gender (Hussein et al., 2016b).

Historically, the UK has relied extensively on immigration to fill labour shortages; first from Commonwealth states, formerly part of the British Empire (Hussein and Manthorpe, 2005). Following early waves of immigration, during the 1960s and 1970s, the UK gradually restricted migration from Commonwealth countries and began to closely link migration policies to economic imperatives such as redressing workforce shortages. However, the UK was one of a minority of EU states that permitted early access to the labour market from the A8 accession countries (The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia; Portes and French, 2005) after they joined the EU in 2004. More recently, in 2011, the UK has introduced an 'immigration cap' on non-EU migrants with the help of a points system (Dobson and Salt, 2006) in order to reduce the number of migrants from this group, particularly those seeking to work in low-skilled jobs.

The marketization and personalization agenda has facilitated an increased role of migrant workers, particularly among those who have arrived from Eastern European countries and are already residents in England. This has been occurring within a context of high demand, increasingly competitive markets for social care that are associated with unattractive work packages including low wages and zero hours contracts. Such conditions are likely to attract vulnerable workers including migrants who are looking for a foothold in the English labour market (Hussein, 2017; Rubery et al., 2015). Trends' analysis utilising the NMDS-SC, presented in Figure 5.1, clearly shows a significantly increased share of Eastern European countries reflecting recent changes in the UK immigration policies. While traditionally migrants from outside the EU constituted the vast majority of migrant workers in the sector, the profile has changed significantly since 2003. Moreover, the analysis shows that from mid-2013 migrants from A2 countries (Bulgaria and Romania) have exceeded non-EU nationals working in the sector for the first time. However, the implications of the Brexit vote, June 2016, are not yet clear on the migrant social care workforce and the sustainability of care

provision in general, given the persistent high vacancy and turnover rates and the sector's inability to recruit enough staff (Hussein et al., 2016a). It is interesting to note that gender dynamics seems to be different among British and migrant care workers. While, the majority of migrant workers recruited to the sector are women, the share of men is higher than that of British workers (25 per cent compared to 17 per cent see Hussein and Christensen, 2017).

Insert Figure 5.1 here

Wages in the English social care sector

The English social sector is characterized by very low pay and difficult working conditions and with fiscal cuts to local government, the social care sector has increasingly become fragmented and casual through outsourcing and other factors (Gardiner and Hussein, 2015; Hussein, 2011b; in press). Evidence of low pay in the sector, particularly among direct care workers, is abundant, with the Low Pay Commission (2014) highlighting the care sector as one of most vulnerable sectors in terms of its workers being paid on or under National Minimum Wage (NMW) thresholds. The NMW came into effect in England during the last nine months of the 20th century (April, 1999), with the care sector arguably one of the main beneficiaries of its introduction. Nonetheless, social care was, and remains, one of the lowest paying sectors in England.

Moreover, the sector has increasingly been suffering from fragmented working-time arrangements, including the widespread use of zero-hour contracts (Rubery et al., 2015), particularly in the home care sector, where migrant workers are over represented (Hussein, 2011a). Wages are, in the majority, attached to actual face-to-face engagement with service users either in care homes or in their own homes and almost no payment is given for other

'tasks' including being 'on call' and travel time between users for home-based care (Rubery et al., 2015; Hussein, 2011b; in press). A recent HM Revenue and Customs (HMRC) campaign targeting employers of social care for adult and older people reflects growing concerns around non-compliance and highlights that inappropriate deductions from pay and accommodation offsets are further drivers of National Minimum Wage underpayment as well as the lack of payment of travel time between clients. Nearly half of the care employers investigated were found to be non-compliant (HMRC, 2013).

The vast majority of participants in LoCS interviews indicated that low pay is the norm in the English social care sector, however, explanations of the reasons underlying this 'fact' were mixed. Thematic analysis of LoCS in-depth interviews identified poor wages as a direct component of the nature of care work. Here there was an implicit, and in some cases explicit, assumption that challenging poor wages or asking for better pay could be regarded as an indication of the unsuitability of an individual to work in the sector. Other determinants observed in the analysis were related to the value the wider society, and consequently the government, places on caring for older people. And the last theme highlighted the impact of current social care policies, particularly marketization and outsourcing, as well as wider fiscal challenges and austerity levels.

The intrinsic nature of frontline care work is often cited as an explanatory factor of the acceptance of low wages and poor working conditions. These intrinsic justifications were expressed by many frontline social care workers themselves, who repeatedly talked about money not being an important element in their decision to work in care. Some managers expressed views that those who would like to obtain a decent wage should not consider working in the sector implying that those who are seeking fair wages may lack the right qualities to be a social care worker.

Many participants in the LoCS study highlighted 'positive' characteristics of the work, such as the ability to work flexibly, as a counter response when asked about their level of pay. However, some participants struggled to convincingly make this argument as payment is attached to strict roles of contact time leaving very little margins for changing circumstances including illness. Yet social care workers seemed to view the problems only in relation to the arrangement of payments rather than the level of wages itself:

> INT: What do you think about your pay and conditions?
>
> RESP: Well pay, conditions? Oh well I think maybe conditions, 'cause if we don't work, we don't get pay, I suppose a lot of firms like that … Okay, yes I was supposed to be on duty today and I wasn't able to go to work, I was sick for whatever reason, then I wouldn't get pay, or if I was at work and I was taken ill a couple of hours after being at work, then I would only get paid for those two hours. (Frontline staff 1033009; LoCS)

The analysis of LoCS interviews indicated general acceptance that poor wages have always been a feature of social care work and it is not likely to change. For some this was concluded to be mainly associated with the wider norms of the society in terms of the value placed on social care work. That it is related to the old, disabled and the weak and working in the sector is not seen as part of a wider 'career'. This theme was evident among a large number of managers and service users and reoccurred over time. Some managers explicitly linked low wages to ageism and the value the society places on looking after older people.

Most employers/managers spoke about the impact of funding cuts on frontline care workers, while acknowledging the fact that care work pay has always been very low. The amount of

pay increases that employers and frontline staff spoke of were very marginal. All wages were governed by the NMW rate but simultaneously working conditions were becoming more difficult particularly in relation to offering sick leave or paying for time spent 'in attendance' between calls or indeed travel time. The very marginal pay increases (5p or 10p) identified by managers were attributed to the austerity measures and progressive outsourcing and privatization in recent years. However, there was some scepticism about the reality of the inability of the private sector to pay a decent wage and some managers questioned the influence of funding cuts on wages. This situation of pushing wages as low as possible is further influenced by the increased private sector share of the market due to the marketization agenda. Many managers argued instead that many private social care providers should be able to afford to pay better wages but they are keeping wages as low as possible to achieve their main goal of high profit margins.

Stress and social care work

Stress for staff have a direct impact on overall service quality and on the retention of good workers, which may affect the quality of service delivery and outcomes (Edwards and Burnard, 2003). Furthermore, previous research shows that such job strain is associated with several adverse health outcomes, most notably cardiovascular disease (Landsbergis and Theorell, 1999; Hallqvist et al., 1998). Social care work can be described as an emotionally taxing work; research demonstrates that moral distress is a serious issue for social care workers who deal with some of the most vulnerable groups in society including older people with dementia and people with severe learning disabilities (Spenceley et al., 2015; Varcoe et al., 2012). Table 5.1 presents Karasek's JCQ scales by social care workers' individual characteristics as derived from the responses to the LoCS staff survey. On average,

participants scored 71.04 on the decision latitude scale (control), 34.96 on psychological job demand (demand), 6.00 on job insecurity and 24.33 on the social support scale. Scores of control and demand from the ostudy resonate with that of Wilberforce and colleagues (2014), who used the same instruments among a sample of care/support workers providing care to individuals who were in receipt of personal budgets in England.

The analysis indicates that job demand, social support and job insecurity vary significantly by some individual characteristics. Table 5.1 shows that women and those who find their personal finances difficult or very difficult to manage, a proxy for poverty-pay, display significantly higher levels of job demand (F=4.105, p=0.046 and F=6.557, p<0.011), while workers from black and ethnic minorities have significantly lower social support. Workers who found their finances difficult to manage also displayed significantly lower job control (F=3.839, p=0.004).

Insert table 5.1 here

Table 5.2 presents the summary statistics on job control, demand, insecurity and social support measures by some job characteristics. There are some significant variations by all job characteristics for both job demand and control. Care workers who were members of trade unions displayed higher levels of job control (F=3.390, p=0.014). Both job control and job demand were significantly lower among frontline workers whose job is 'all hands on care', referring to those who work directly with service users providing intimate and personal care (F=8.07 and 37.00, p<0.001). Job demand and control were significantly higher among workers who were members of any trade union (F=8.26, p=0.004; F=131.13, p<0.001). Job insecurity seemed to vary the most according to the nature of the job, with those in

administrative posts or with little care responsibilities (F=3.27, p=0.021 and by sector, with those in the public sector having the highest levels of job insecurity (F=19.04, p<0.001).

It is surprising to note that those who indicated they belong to trade unions displayed significantly higher levels of job insecurity (F=23.07, p<0.001). These differences are likely to be related to austerity measures and public cuts, where workers employed in the public sector, who are more likely to be members of trade unions, feel higher levels of job insecurity. It is also likely that those who belong to trade unions are likely to have joined because they are not highly satisfied with various elements of their work and thus represented a selected group who are already dissatisfied. Interestingly the analysis shows that social support only varies according to ethnicity, union membership and sector of work, with those working in voluntary sector reporting the lowest social support levels (which is a combination of co-workers' and supervisors' support).

Insert Table 5.2 here

The concept of 'moral distress' could be employed to understand the nature of stress experienced by long-term care workers. This concept can be identified as 'the pain or anguish affecting the mind, body, or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgement about the correct action' (Nathaniel, 2004). Analysis of in-depth interviews from LoCS identified a number of situations when 'moral distress' could be experienced by social care workers. These include situations when a perceived tension between rights and protection occur; when workers are faced with users' challenging behaviour; when there are discrepancies between the perceived right course of action and workers' ability to take such a decision; and when time and 'task' constrain their ability to provide the 'right' care. A

specific tension occurred when workers' duty to 'protect' collided with what they felt to be tailored and personalised care. These tensions caused dilemmas for care workers that could be manifested in feelings of inability to provide high quality care that in turn could be a factor of distress to the workers.

> There is so much paperwork. If a resident falls or trips over a pair of steps, it's not because oh he's tripped up. They don't do that any more. Look where you are going. You can't say that. You have to write a risk assessment out … It does,[she points to her heart] that's exactly how it makes you feel. They can't go out in the snow, because they might fall over and hurt themselves. The joy that I had when I was a kid of running in the snow and rolling in the snow and that sort of thing is lost for them.
> (Older people care home worker, 2105008; LoCS)

Challenging behaviour and use of restraints can also be a cause of moral distress to many social care workers. A particular stressor could be viewed in relation to how challenging behaviour, communication and workers' perception of best practice interact and influence workers' decisions about job quitting:

> People just resign … at times, after a year, even huge turnover in management, it's affected in that house as well, because of the workload, staff conflict. Staff not feeling they are supported enough.
> (Employer, 1072001, LoCS)

The fact that social care workers provide care to the most vulnerable people, some of whom may lack cognitive/mental capacity or suffer from extreme memory problems can pose a number of challenges and impact on workers' stress. It is plausible that social care workers

could be accused of abusive behaviour if it proved difficult to establish the exact circumstances surrounding an incident where service users are hurt for example. Frontline care staff provided several examples when similar situations caused them unnecessary stress, when they either needed to defend themselves or wanted to protect the people they cared for. This residential care worker explains one of these situations:

> We took Paul to the doctors and again because of the autism in that communication obstacles, he couldn't translate the actual problem to the doctor very well and Paul had—with [specific] Syndrome they bruise easily. They can just accidentally walk into a table and they get a massive bruise or something like that. The doctor decided making investigative questions and enquiries about abuse. Paul only went there for like a cold or something. It's a whole thing that doctors and nurses just assume they know better.
> (Residential care worker, 2105012; LoCS)

Most participants identified training and support from supervisors and co-workers to be important in their ability to deal with these situations. However, many also mentioned talking to partners and family members about work stressors, which indicates a certain degree of stress spilling over to family life.

Discussion

The English social care system is less universal and more complex than in many other European countries, particularly social-democratic welfare states such as Scandinavian countries. England was one of the first European countries to marketize care through

progressive policies of privatization and outsourcing leading to transforming care into a commodity that is governed by market forces with a large share of for-profit organizations. These dynamics create increasing pressures to maximise profit, in the main through reducing staff cost, which accounts for nearly 60 per cent of residential care and 80 per cent of domiciliary care total cost (Care Quality Commission, 2016). The result has been increasingly low wages, precarious working arrangements and fewer job security measures. Similarly to many other countries, the English social care sector relies on women and migrants who are more likely to accept 'bad jobs' (Kalleberg, 2011) – that is jobs that are low paid, have weak contractual protection with little job security and require low levels of qualifications.

Migrants have continued to form a significant part of the British social care sector, however, since 2003 there have been considerable changes in the profile of these migrants, particularly in relation to source country. The findings based on analysis of the NMDS-SC indicate that while 10 years ago migrants from outside the EU (mainly nurses from the Philippines) constituted the vast majority of migrant workers in the English adult social care sector, by 2014 the major group of migrants were from A2 countries (Bulgaria and Romania). The future UK immigration policies are currently very uncertain with the recent vote of British citizens to leave the EU. The implications of Brexit on adult and older people's social care provision and markets remain to be seen but are likely to be significant given the continuous reliance of the English adult social care sector on migrants.

The evidence presented here indicates that the English low-skilled, low-status, adult social care work carries considerable wage penalties for a considerable part of its highly vulnerable workforce. Several authors explain low wages in social care by the intrinsic nature of care work itself and the vulnerability of those who choose and associate with this work (Duffy et al., 2013). It is argued that the reward gained from the inherent nature of working with

vulnerable individuals in need of care can increase frontline workers' job satisfaction and feelings of self-worth to a certain degree to compensate for the bad qualities of the job, including very low wages (Morgan et al., 2013; Rakovski and Price-Glynn, 2010). Some argue that the acceptance of poor working conditions can relate to a concept of self-sacrifice adopted by some workers as a way of affirming their own identity at work, where they are seen, by others and themselves, as placing their values ahead of their own needs (Baines and Cunningham, 2011). The analysis presented here, confirms these arguments to a certain extent and thus poses several questions on how to enable the sector to re-evaluate the worth of its work taking into account the wider social and economic costs of poverty pay, stress and potential health outcomes. This process needs to consider the particular vulnerability associated with many individuals working in this workforce, especially in relation to gender and migration status.

Additionally, the value a society places on the act of caring for older people and those who are 'weak', such as disabled people and those with mental health problems, can also be considered as an explanatory factor of consistently low wages in the social sector, where ageism and discrimination not only affect those individuals but also those working with them (Stone and Harahan, 2010). The analysis shows that this is a view shared by many managers and service users who participated in the LoCS study. Moreover, marketization of care presents a situation where care providers operate within a tight public funding structure, meaning that private companies have to enhance their profits through higher fees for self-funding care users, maintaining low wages and increasing workers' productivity through shorter visits to perform more tasks or by increasing the ratio of care recipients per worker (Folbre, 2012).

Persistent low wages and increasingly difficult working conditions carry a heavy penalty for social care workers, particularly those who could be considered as vulnerable workers. Prime among this group of social care workers are women and migrants who may lack other employment options or who have other responsibilities and constraints that prevent them from seeking alternative work. Thematic analysis of the in-depth interviews of LoCS shows that moral distress among frontline workers can occur in a number of situations, particularly when there is lack of job authority to ensure that the perceived appropriate actions can be undertaken. Training and support from co-workers and supervisor was identified as important in reducing the effect of stress. However, the majority of participants indicated that lack of time and increased workload impact negatively on their ability to manage work related stress.

Conclusion

Migrants and women continue to form a significant part of the English social care workforce; the findings presented here show that many of those workers, particularly those who find their finances difficult to manage, are more prone to higher levels of stress that are associated with various risks to individual workers as well as to the sector as a whole, including high turnover rates and reduced quality of care. With escalating demands on the formal social care sector, it is crucial to implement both policy and practice measures to reduce poverty-pay, job demand and insecurity among social care workers. These need to be viewed as preventative strategies to maintain the well-being of workers as well as the quality of care to the most vulnerable in society. Such strategies should acknowledge the stressful nature of care work and address possible situations where many workers are subjected to various forms of 'moral distress'. These are likely to impact not only on workers' ability to complete their work to the highest

quality but also have potential negative impact on their own well-being and the likelihood of job quitting.

References

Baines, D. and Cunningham, I., 2011. 'White knuckle care work': violence, gender and new public management in the voluntary sector. *Work Employment and Society,* 25(4), pp.760–76. http://dx.doi.org/10.1177%2F0950017011419710

Brennan, D., Cass, B., Himmelweit, S., and Szebehely, M., 2012. The marketization of care: rationales and consequences in Nordic and liberal care regimes. *Journal of European Social Policy,* 22(4): 377-391. DOI: 10.1177/0958928712449772

Care Quality Commission, 2016. *The state of health care and adult social care in England 2015/16.* London: House of Commons. Available at: http://www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf [Accessed 15.07.2017].

Christensen, K. and Pilling, D., 2014. Policies of personalisation in Norway and England: on the impact of political context. *Journal of Social Policy*, 43(3), pp.479–96. DOI: 10.1017/S0047279414000257

Department of Health (DoH), 2014. *Care and support statutory guidance issued under the Care Act 2014* , London: Department of Health. Available at: https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation [Accessed 15.07.2017].

Department of Health (DoH), 2006. *Our health, our care, our say: a new direction for community services*. London: The Stationery Office. Available at: https://www.gov.uk/government/publications/our-health-our-care-our-say-a-new-direction-for-community-services[Accessed 15.07.2017].

Dobson, J. and Salt, J., 2006. Foreign recruitment in health and social care: recent experience reviewed. *International Journal of Migration, Health and Social Care,* 2 (3/4), pp.41–57. DOI: 10.1108/17479894200600026

Duffy, M., Albelda, R. and Hammonds, C., 2013. Counting care work: the empirical and policy applications of care theory. *Social Problems*,60(2), pp.145–67. DOI: 10.1525/sp.2013.11051

Edwards, D. and Burnard, P., 2003. A systematic review of the effects of stress and coping strategies used by occupational therapists working in mental health settings. *British Journal of Occupational Therapy*, 66(8), pp.345–55. http://dx.doi.org/10.1177%2F030802260306600803

Esping-Andersen, G. , 1999. *Social foundations of post-industrial economies.* Oxford: Oxford University Press.

Ferguson, I. , 2007) Increasing user choice or privatizing risk? The antinomies of personalisation. *British Journal of Social Work*, 37(3), pp.387–403. DOI: https://doi.org/10.1093/bjsw/bcm016

Folbre, N., 2012. *Love and money*. *Care provision in the United States*. New York: Russell.

Gardiner, L. and Hussein, S., 2015. *As if we cared: the costs and benefits of a living wage for social care workers.* London: The Resolution Foundation. Available at: http://www.resolutionfoundation.org/app/uploads/2015/03/As-if-we-cared.pdf [Accessed 15.07.2017].

Hallqvist, J., Diderichsen, F., Theorell, T., Reuterwall, C., and Ahlbom, A., 1998. Is the effect of job strain on myocardial infarction risk due to interaction between high psychosocial demands and low decision latitude? Results from Stockholm Heart Epidemiology Program (SHEEP). *Social Science Medicine*, 46, pp.1405–15. Avaiable at: http://www.sciencedirect.com/science/article/pii/S0277-9536(97)10084-3 [Accessed 20.07.207].

HM Revenue and Customs, 2013. *National minimum wage compliance in the social care sector. An evaluation of national minimum wage enforcement in the social care sector over the period 1st April 2011 to 31st March 2013*, HMRC, London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262269/131125_Social_Care_Evaluation_2013_ReportNov2013PDF.PDF [Accessed 15.07.2017].

Humphries, R., Thorlby, R., Holder, H., Hall, P. and Charles, A. (2016) Social care for older people: home truths. The King's Fund and Nuffield Trust. Available at: https://www.kingsfund.org.uk/publications/social-care-older-people [Accessed 20.072017].

Hussein, S., 2011a. Migrant workers in long-term care: evidence from England on trends, pay and profile. *Social Care Workforce Periodical*, Issue 12: March 2011, London. Available at: http://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/periodical/issues/scwp12.pdf [Accessed 15.07.2017].

Hussein, S., 2011b. Estimating probabilities and numbers of direct care workers paid under the national minimum wage in the UK: A Bayesian approach. *Social Care Workforce Periodical*, Issue 16: December 2011 London. Available at: http://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/periodical/issues/scwp16.pdf [Accessed 15.07.2017].

Hussein, S., 2017. 'We don't do it for the money' ... The scale and reasons of poverty-pay among frontline long term care workers in the United Kingdom. *Health and Social Care in the Community.* 12th June 2017, DOI: 10.1111/hsc.12455.

Hussein, S. and Christensen, K., 2017. Migration, gender and low-paid work: on migrant

men's entry dynamics into the feminised social care work in the UK. *Journal of Ethnic and Migration Studies,* 43(5), pp.749–65. DOI: 10.1080/1369183X.2016.1202751

Hussein, S. and Manthorpe, J., 2005. An International review of long-term care workforce: policies and shortages. *Journal of Aging and Social Policy,* 17(4), pp.75–94. DOI: 10.1300/J031v17n04_05

Hussein, S. and Manthorpe, J., 2014. Structural marginalisation among the long-term care workforce in England: evidence from mixed-effect models of national pay data. *Ageing and Society,* 34(1), pp. 21–41. DOI: 10.1017/S0144686X12000785

Hussein, S., Ismail, M. and Manthorpe, J., 2016a. Changes in turnover and vacancy rates of care workers in England from 2008 to 2010: Panel analysis of national workforce data. *Health & Social Care in the Community,* 24(5), pp.547–56. DOI: 10.1111/hsc.12214

Hussein, S., Ismail, M. and Manthorpe, J., 2016b. Male workers in the female-dominated long-term care sector: evidence from England. *Journal of Gender Studies*. 25(1), pp.35–49. DOI: 10.1080/09589236.2014.887001

Kalleberg, A., 2011. *Good jobs, bad jobs: the rise of polarised and precarious employment in the United States, 1970s-2000s.* Russell Sage Foundation

Karasek, R., Brisson, C., Kawakami, N., Houtman, I., Bongers, P.,and Amick, B., 1998a. The Job Content Questionnaire (JCQ): an instrument for international comparative assessments of psychosocial job characteristics. *Journal of Occupational Health Psychology*, 3, pp.322–55. Available at: http://arnekalleberg.web.unc.edu/files/2014/10/GJBJ.Book-Reviews.pdf [Accessed 15.07.2017].

Karasek, R., Triantis, K., and Chaudhry, S., 1998b. Coworker and supervisor support as moderators of associations between task characteristics and mental strain. *Journal of Occupational Behavior*, 3 (2), pp.181–200.

Landsbergis, P. and Theorell, T., 1999. Measurement of psychosocial workplace exposure variables. Self-report questionnaires. *Occupational Medicine*, 15, pp.163–71.

Low Pay Commission, 2014. *National minimum wage: low pay commission report 2014*. London. Available at: https://www.gov.uk/government/publications/national-minimum-wage-low-pay-commission-report-2014 [Accessed 15.07.2017].

Morgan, J., Dill, J. and Kalleberg, A., 2013. The quality of healthcare jobs: can intrinsic rewards compensate for low extrinsic rewards? *Work Employment and Society*, 27(5), pp.802–22. DOI: 10.1177/0950017012474707

Nathaniel, A. K., 2004. A grounded theory of moral reckoning in nursing. *The Grounded Theory Review*, 4(1), 45–58. Available at: http://groundedtheoryreview.com/2004/11/29/1599/ [Accessed 15.07.2017].

Portes, J. and French, S., 2005. *The impact of free movement of workers form central and Eastern Europe on the UK labour market: early evidence*. Department for Work and Pension, Working paper 18, London.

Rakovski, C. and Price-Glynn, K. 2010. Caring labour, inter-sectionality and worker satisfaction. *Sociology of Health and Illness*, 32(3), pp.400–414. DOI: 10.1111/j.1467-9566.2009.01204.x

Rubery J., Grimshaw, D., Hebson, G. and Ugarte, S.M., 2015 "It's all about time": time as contested terrain in the management and experience of domiciliary care work in England. *Human Resource Management*, 54(4), pp.753–72. DOI: 10.1002/hrm.21685

Skills for Care, 2016. The state of the adult social care sector and workforce in England. Leeds. Available at: https://www.nmds-sc-online.org.uk/Get.aspx?id=980099 [Accessed 15.06.17].

Spenceley, S., Witcher, C., Hagen, B., Hall, B. and Kardolus-Wilson, A., 2015. Sources of

moral distress for nursing staff providing care to residents with dementia. *Dementia*, [online.] DOI: 10.1177/1471301215618108.

Stone, R. and Harahan, M.F., 2010. Improving the long-term care workforce serving older adults. *Health Affairs,* 29(1), pp.109–15. doi: 10.1377/hlthaff.2009.0554

Varcoe, C., Pauly, B., Storch, J., Newton, L., and Makaroff, K., 2012. Nurses' perceptions of and responses to morally distressing situations. *Nursing Ethics*, 19(4), pp.488–500. DOI: 10.1177/0969733011436025

Wilberforce, M., Jacobs, S., Challis, D., Manthorpe, J., Stevens, M., Jasper, R., Fernandez, J.L., Glendinning, C., Jones, K., Knapp, M., Moran, N., and Netten, N., 2014. Revisiting the causes of stress in social work: sources of job demands, control and support in personalised adult social care. *British Journal of Social Work*, 44, pp.812–30. DOI: 10.1093/bjsw/bcs166

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The analysis presented in this chapter was funded by the English Department of Health, Policy Research Programme (DH/035/0095). The views expressed are those of the author alone and do not necessarily represent that of the Department of Health. I am grateful to all those who participated in the interviews or completed the survey. I thank colleagues at the Social Care Workforce Research Unit.