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Ethnicity at work: the case of British minority workers in the long-term care sector

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Abstract

Purpose: The aim of this paper is to explore the effect of ethnicity and separate this from the other dynamics associated with migration among members of the long-term care workforce in England focusing on the nature and structure of their jobs. The analysis examines interactions between ethnicity, gender, and age, and their relations with 'meso' factors related to job and organizational characteristics and 'macro' level factors related to local area characteristics.
Methodology: We analyse new national workforce data, the National Minimum Data Set for Social Care (NMDS-SC), n= 357,869. We employ descriptive statistical analysis and a set of logistic regression models.
Findings: The results indicate that labour participation of British BME groups in long-term care work is much lower than previously believed. There are variations in nature of work and possibly job security by ethnicity.
Research limitations: While the national sample is large, the data were not purposively collected to examine differentials in reasons to work in the care sector by different ethnicity.
Practical implications: the analysis highlights the potential to actively promote social care work among British BME groups to meet workforce shortages, especially at a time where immigration policies are restricting the recruitment of non-European Economic Area nationals.
Social implications: Issues related to recruitment disparities as well as inequalities in relation to job security call for human resource strategies that are more proactive and for the vigilance of trade unions and professional groups.
Originality: The analysis provides a unique insight into the participation of British BME workers in the long-term care sector, separate from that of migrant workers.

Background

"Ethnicity" is a socially constructed concept, with little biological validity, that is key to an individual identity as well as how a person is perceived by society. Ethnic identity may be used as a political symbol, defining possible exclusion by a powerful majority but also giving rise to pride and belonging for a minority (Parekh 2006). People may use ethnicity in addition to other visible markers, such as skin colour and dress code, as a way of grouping others in a 'normative order', sometimes to evaluate others, despite knowledge that such characteristics are not associated with physiological or other differences (Hauskeller 2006, Li 2008, Johnstone and Kanitsaki 2008). The literature suggests that people from different minority ethnic groups, particularly those with visible social markers, are likely to experience different levels of overt and covert racism and discrimination in the workplace (Doyle and Timonen 2009, Holgate 2005, Stevens et al 2012).

Ethnicity and nationality are two overlapping but different elements of a person's identity that are constructed through heritage, community and norms. There has been recent interest in understanding the profile of recent migrants working in the care sector in the United Kingdom (UK) and other economically developed countries (see, for example, Browne and Braun 2008; Cangiano et al 2009) and international acknowledgement that high proportions of the care workforce are from minority groups (see Delp et al 2011; PHI 2011). However, little is known about the current position of British citizens who are not recent migrants but are members of Black and Minority Ethnic (BME) groups and are working the UK care sector. The choice of care work for migrants may, at least partially, be influenced by the desire to migrate in the first place (Hussein et al 2012), while British BME people may be influenced by different factors. Of course, BME individuals in the UK are not homogenous as socio-economic, religious and cultural factors vary across different BME communities. However, many studies have highlighted the importance of parents' influence over career choices made by young BME people (Connor et al 2004, Greenwood et al 2006, Helm 2002).

Specific to the long-term care sector, Robinson and colleagues (2006) identified negative perceptions of some health and social care careers among different BME groups in the UK. For example, these jobs may be perceived as highly stressful with poor working conditions and pay. These assumptions might also influence BME students' experiences in professional education, for example, research on social work has indicated that Black students may be less likely to progress and qualify on time (Hussein et al 2009, Bernard et al 2011). The overall reasons for such perceptions are multi-faceted and may include perceived difficult working conditions, poor pay, needs for financial support during study, and fear of institutional racism (Klem and Notter 2001, Giga et al 2008; Bernard et al 2011).

The UK has been multi-cultural for many decades, specifically with large-scale migration from former colonies after the Second World War in varying patterns. Many such immigration waves were prompted by labour needs in the UK, for example, large labour-related movements from Pakistan and India in the 1960s and 70s. Currently, over 50 per cent of people identified as having Asian or Black ethnicity were born in the UK (Ahmad and Bradby 2007) and so are British nationals and not recent migrants. Additionally, other 'invisible' minorities have long been part of British society, for example, people from Ireland or travelling communities. More recent changes in migration patterns, political changes, European Union expansion and globalization in general have further enriched the mixture of ethnicities in the UK to the extent that the country has been referred to as 'superdiverse' (Finney and Simpson 2009).

According to the latest census data (2011; ONS 2012), 86 per cent of the UK population is White, which includes significant White minorities such as Irish people. Black and Minority Ethnic (BME) people are concentrated in urban areas, particularly in deprived areas, where they make up a much bigger share of the population. The UK is likely to become further multi-ethnic in the future. BME groups now account for 73 per cent of the UK's total population growth, due to differences in fertility rates and inward migration (Parliament Office of Science and Technology 2007).

The UK may be a diverse society, and growing more diverse every year, however, health and socio-economic ethnic inequalities in life chances, including employment opportunities and career progression, are very wide (ONS 2009, Hills 2010). The increasing diversity of people who are receiving social care services, for example, elderly frail people (Lievesley 2010), suggests the benefits of a diverse workforce reflective of the population it serves. In addition to inequalities in service access and some assumptions that some ethnic groups '*look after their own*' (Butt and O'Neil 2004), there are considerable inequalities within the social care workforce. In the UK the term social care includes care homes (nursing homes and assisted living facilities); home care (home health care) and other community-

based services, such as day centres, but not primary care nursing. Within this workforce discrimination and racism are widely reported, especially among migrant workers or workers who 'look' different (Hussein et al 2010, Cangiano et al 2009). British BME staff sometimes similarly may be subjected to racism and discrimination (Stevens et al 2012). Visible social markers, such as skin colour, may trigger racist behaviour among other staff or people using social care services.

The aim of this paper is to explore the relationship between ethnicity and employment in the care sector, separating this from the other dynamics associated with recent migration. While individual characteristics and identities are important in job seeking and career progression experiences, macro and meso factors are also influential. Local labour market opportunities and overall prosperity levels, for example, intersect with gender and race in labour participation dynamics (Browne and Misra 2003). Similarly, meso factors related to organisational structure, management styles and practice play key roles in (dis)empowering minority groups (Syed and Özbilgin 2009).

As a first step this article examines the profile and contribution of British BME workers in the English social care sector, drawing on comparison with similar British citizens but who belong to the majority White ethnicity. Once the contribution of this group is established, we examine how organisational and local area characteristics influence the levels of employment of British BME workers and their job patterns in social care. The latter analysis serves to examine a number of conceptual associations: first to test theoretical links between deprivation levels and (over)utilisation (employment) of BME groups in the sector, and second to examine whether BME workers (when compared to 'White British' workers) are concentrated in the lower hierarchies of jobs and working conditions (e.g. employed in less managerial jobs or concentrated in areas with evidence of lower pay levels). To achieve this we analyze new national workforce data, the National Minimum Data Set for Social Care (NMDS-SC), updated June 2011, exploring the specific profile of BME workers in the social care workforce in England. The analysis thus examines the interactions between three main facets of identity: ethnicity, gender, and age, and their relations with 'meso' factors related to job and organizational characteristics and 'macro' level factors related to local area characteristics.

Data and Methods

The NMDS-SC is a national collection of data about the social care workforce in England. Returns to the dataset have been completed by increasing numbers of employers registered to provide social care since 2007 in all regions in England. In 2012, the NMDS-SC gained 'national statistics' data status in England. Employers provide aggregate information on their workforce as well as detailed records related to individual workers. Since 2010, the NMDS-SC has collected information on workers' nationality in addition to previously collected characteristics including ethnicity. While the NMDS-SC collects information on disabilities (in the form of any reported disability which may cover physical and mental ill health or long-term conditions) it does not collect information on other factors influencing identity, including religious or sexual orientation.

Completion of the NDMS-SC by employers is not currently compulsory but there are some financial and training incentives. Skills for Care (SfC) estimates that the NMDS-SC covers over 50 per cent of Care Quality Commission (CQC) registered social care providers (employers) in England, in addition to a large group of non-registered employers (such as small private and direct employers)[1]. While the NMDS-SC does not provide a complete census of the social care workforce in England, initial data investigation has not indicated bias among employers who complete the NMDS-SC. The profiles of employers completing the workforce and the profile of the workforce itself are highly consistent with overall

estimates of the national workforce (Skills for Care 2010), the one exception being the low representation of 'direct' employers, individuals employing care workers themselves.

The NMDS-SC, June 2011, provided information on a total of 646,926 workers. Following the recent introduction of collection of nationality data, 357,869 of these workers' records contained valid information on both ethnicity and nationality. The latter sample of records was found to be satisfactorily representative of the overall NMDS-SC in relation to main job characteristics in the sector (Hussein 2011a).

We acknowledge that all ethnic classifications have their critics but some argue that even so there is merit in investigating if there are ethnic variations or disparities (Aspinall and Jacobson 2007). Likewise, some researchers have recently proposed that it may be particularly helpful to explore 'absolute levels of particular outcomes and drawing multiple comparisons between groups (rather than simply using a majority White comparator)' because this may help to avoid overlooking important issues facing minority groups which are similar to those experienced by the majority (Salway et al 2009, p3-4). We agree with such ambitions and attempt not to overlook such similarities in our analysis. While measuring race is a complex process, for the purpose of this article and arising from the current analysis we will focus on a specific group of British BME workers: namely those identified by their employers not to be recent migrants (i.e. British citizens) and belong to non-White ethnicity (hereafter termed British BME). This definition allows us to separate theoretical differences in the recruitment and experiences of work that are related to being a 'migrant' from that related to belonging to a minority race or ethnic group while having full citizenship rights.

The current analysis starts by outlining the context of workforce composition with a focus on ethnicity and explores the interactions between ethnicity and other personal, employment and organizational characteristics. To achieve this we focused only on those identified as 'British' workers (reported as UK citizens) and compared the profile of White and BME British workers (n=307,575 British workers), thus excluding all workers identified by employers as non-British citizens and hereafter referred to as migrants.

To investigate the possible association between the geographical characteristics of an area and the prevalence of British BME workers, we used rural-urban classifications down to Council with Social Services Responsibility (CSSR) level[2]: with the three-way classifications of 'Predominantly Rural' (R50 and R80), 'Significant Rural' (SR) or 'Predominantly Urban' (OU, MU and LU) being obtained for each CSSR area. The Rural/Urban definition, an official National Statistic introduced in 2004, defines the rurality of very small census-based geographies[3]. These data were linked to the NMDS-SC provision dataset.

We used forward step-wise logistic regression models to examine differences in the profile and distributions of British BME workers within the care sector in comparison to their White British counterparts. The models started by including all individual, work and organisational characteristics listed in Tables 1 - 3 then retained only those with significant association with the independent variable: being a British citizen from an ethnic minority group. A total of 279,415 workers' records were included in the final model, which had an Area Under Curve (AUC) measure of 0.78 indicating its very good discriminatory power. Analyses were conducted using R Statistical Environment (ver 2.1) on Unix (R Development Core Team 2007).

Findings

The Social Care Workforce in England

Social care is an employment sector in which some ethnic groups appear to be over-represented while others are under-represented compared to the overall population. Available data, mainly from the NMDS-SC, indicate that overall between 80 per cent and 85 per cent of this workforce is White, although this proportion varies within different settings;

for example, it is higher in domiciliary (home care) than in residential care (care homes with and without nursing care) (Hussein 2011a). The proportion of BME staff further varies in different settings and sectors, ranging from an estimated 25 per cent in independent (private and voluntary) sector care homes with nursing, 15 per cent in domiciliary care, and nine per cent in day care services. In 2009, around 85 per cent of all adult social care jobs were held by White staff and 15 per cent by BME staff. In local authorities and the NHS (where some staff undertaking social care are employed if local services are integrated), around 80 per cent of social workers and 90 per cent of occupational therapists are White (Skills for Care 2010). However, these figures do not distinguish between migrants and British BME workers and consequently may overestimate the contribution of 'British' BME workers. This would have implications for recruitment and equal opportunities since the sector may be under a false sense of confidence that it is more responsive to diversity than is the case.

The current analysis of the NMDS-SC, June 2011, focusing on workers about whom there is valid information on both ethnicity and nationality, shows that 7.5 per cent (n=26,789) of workers were identified by their employers as British BME workers. This percentage is much lower than the 19 per cent identified as belonging to BME groups without accounting for nationality, when calculated from the same dataset. A total of 14 per cent were identified as migrants, with 3 per cent being White migrants (e.g. from Australia or EU countries). Focusing on those identified as British (n=307,575), 91.3 per cent are reported as having 'White' ethnicity and 8.7 per cent (n=26,789) as being from BME groups. Among BME workers, 38 per cent were identified as Black or Black British, 30 per cent as 'Other' ethnicities, 22 per cent as Asian or Asian British, and 10 per cent as mixed.

Personal Profile

Table 1 indicates that the average age of both BME and White British workers is in the early 40s, albeit a slight younger age among British BME workers ($\bar{X}$ = 41.3 vs. 42.5 years; σ =12.5 and 13.5; median= 42 vs. 44 years). In terms of gender, 11.6 per cent of British BME workers are men, this compares to only 8 per cent of British White workers. More White British workers were identified as having any form of disability than BME British workers (1.8% vs. 1%; χ^2=569.8, p<0.001); such differences are examined further in the analysis.

Table 1 NMDS-SC sample description of BME and White British workers personal characteristics

Personal Characteristics	White British	BME British
Age		
mean (n; sd)	42.5 (280,786; 13.5)	41.3 (26,789; 12.5)
Men % (n)	8.2 (280,232)	11.6 (26,729)
Disability % (n)	2.4 (276,150)	1.3 (26,157)
Highest qualification		
Entry/level1	1.2%	1.1%
Level 2	41.6%	38.4%
Level 3	26.2%	25.2%
Level 4	11.6%	10.8%
Other relevant qualifications	15.1%	12.5%
No relevant qualifications	4.3%	12.0%
Number of cases†	139,524	11,198

† Excluding missing values

Source of Recruitment

Information on source of recruitment was provided for some workers. Employers reported that significantly higher proportions of White British workers had been recruited from retail and other sectors than BME British workers. For example, 5 per cent of White British workers had been recruited from the retail sector to their current jobs in social care compared to only 2 per cent of their BME counterparts (see Table 2). Similarly, 11 per cent of the former group had been recruited from other sectors compared to only 7 per cent among the latter group. On the other hand, relatively more BME British workers were recruited through employment agencies or from the health sector. Significantly more British BME workers had been recruited through employment agencies than White British workers (9% vs. 2%; χ^2=157.8, p<0.001).

Table 2 NMDS-SC sample description of BME and White British workers job characteristics

Job Characteristics	White British	BME British
Main job role		
Direct Care	71.6%	79.6%
Manager/Supervisor	8.9%	7.1%
Professional	4.0%	6.0%
Other	15.5%	7.3%
Number of cases	280,786	26,789
Work Pattern		
Permanent	88.3%	80.2%
Temporary	3.3%	8.8%
Bank or pool	5.8%	6.6%
Agency	1.5%	3.5%
Student	0.1%	0.0%
Volunteer	0.1%	0.1%
Other	0.9%	0.8%
Number of cases	277,251	26,519
Source of recruitment to current job		
Social care sector	51.30%	46.10%
Health sector	5.30%	7.90%
Retail sector	4.50%	2.20%
Other sectors	10.50%	6.60%
Not previously employed	3.90%	3.00%
From abroad	0.10%	1.10%
Agency	2.40%	8.80%
Other sources	22.10%	24.30%
Number of valid cases†	170,989	11,970

† Excluding missing values

Organizational characteristics and ethnicity

To understand further which organizational and personal characteristics appeared more likely to increase the likelihood of British BME participation in the social care workforce, while controlling for other factors, we conducted a logistic regression model with

the outcome being whether a worker belongs to a BME group or not. We included several personal and organizational variables as 'independent' factors. Descriptive characteristics are presented in Tables 1 to 3, and the final model showing factors associated with the probability of a worker being from a British BME group is presented in Table 4. The analysis indicates significant differences between British BME and White British groups at different levels, including personal, local area, organizational, and job characteristics.

Table 3 NMDS-SC sample description of BME and White British workers local and organisational characteristics

Local and organisational Characteristics	White British	BME British
Mean turnover rate (n; sd)	24 (276,173; 79.6)	22.5 (26,219; 80)
Mean vacancy rate (n; sd)	2.2 (276,173; 6.1)	2.2 (26,219; 7)
Local area level of rurality		
Predominantly Rural	22.5%	15.0%
Predominantly Urban	42.9%	66.5%
Significant Rural N	34.6% 280,426	18.5% 26,742
Service Type		
Adult residential	53.6%	55.6%
Adult Day	2.9%	2.5%
Adult domiciliary	31.7%	33.0%
Adult community care	4.6%	4.7%
Children's services	1.6%	1.0%
Healthcare	0.03%	0.1%
Other	5.7%	3.3%
Number of cases	280,786	26,789
Sector		
LA	11.3%	7.1%
Private	61.1%	65.9%
Voluntary	23.2%	24.2%
Other	4.4%	2.8%
Number of cases†	280,786	26,789

† Excluding missing values

At the level of personal characteristics, British BME workers are significantly less likely to be women (Odds Ratio (OR) = 0.71; $p<0.001$) and to report any form of disability (OR=0.60; $p<0.001$). British BME workers are significantly more likely to hold entry/level 1 qualifications, other (not directly relevant e.g. trade-related) qualifications or not hold any qualifications at all than NVQ level 2 when compared to White British workers (OR=1.75, $p<0.001$; OR=3.08, $p<0.001$; OR=1.73, $p<0.001$ respectively).

Table 4 Results of the final logistic regression model (AUC= 0.78)

Significant variables in final logistic regression model	Odds Ratio	Confidence Interval		Std. Error	z value	*p*-value
		Lower bound	Upper bound			
PERSONAL CHARACTERISTICS						
Women vs. men	0.71	0.68	0.74	0.02	-18.4	<0.001§
Any disability vs. none	0.60	0.52	0.68	0.07	-7.3	<0.001§
Highest qualification level (ref: Lev 2)⊥						
Not recorded	0.78	0.73	0.82	0.03	-8.5	<0.001§
Entry/Level1	1.75	1.42	2.15	0.11	5.3	<0.001§
Level 3	0.91	0.86	0.96	0.03	-3.3	0.001‡
Level 4	0.99	0.91	1.07	0.04	-0.3	0.768
Other relevant qual.	0.95	0.89	1.02	0.04	-1.3	0.193
Any other qual.	3.08	2.85	3.33	0.04	28.1	<0.001§
No qual. held	1.73	1.67	1.81	0.02	26.6	<0.001§
ORGANISATIONAL CHARACTERISTICS						
Sector (ref: Local authority)						
Private	1.34	1.25	1.43	0.03	8.6	<0.001§
Voluntary	0.80	0.74	0.85	0.04	-6.5	<0.001§
Other	0.83	0.75	0.92	0.05	-3.6	<0.001§
Turnover rate (ref: low)						
Medium	1.07	1.04	1.11	0.02	3.9	<0.001§
High	0.90	0.87	0.93	0.02	-5.6	<0.001§
Vacancy rate high vs. low	0.72	0.69	0.75	0.02	-16.5	<0.001§
Type of setting (ref: residential)						
Adult Day	0.62	0.56	0.68	0.05	-9.7	<0.001§
Adult domiciliary	0.47	0.46	0.49	0.02	-40.0	<0.001§
Adult community care	0.71	0.66	0.76	0.04	-8.8	<0.001§
Children's services	0.72	0.62	0.83	0.07	-4.5	<0.001§
Healthcare	3.91	0.91	15.41	0.70	1.9	0.053
Other	0.51	0.46	0.55	0.04	-15.3	<0.001§
JOB CHARACTERISTICS						
Main job role (ref: direct care)						
Manager/Supervisor	0.80	0.75	0.85	0.03	-7.2	<0.001§
Professional	2.26	2.11	2.42	0.03	23.3	<0.001§
Other	0.48	0.46	0.51	0.03	-25.6	<0.001§
Employment status (ref: permanent)						
Other	0.73	0.68	0.78	0.04	-8.9	<0.001§
Temporary	2.11	1.98	2.25	0.03	23.3	<0.001§
Agency	1.47	1.33	1.62	0.05	7.8	<0.001§
Work pattern (ref: full time)						
Part-time	0.96	0.93	0.99	0.02	-2.6	0.011†
Neither of these	1.38	1.30	1.46	0.03	10.6	<0.001§
Induction (ref: completed)						
Induction in Progress	0.97	0.92	1.02	0.02	-1.2	0.217
Not applicable	0.69	0.66	0.73	0.02	-15.9	<0.001§
Service users						
Adults with LD	1.90	1.84	1.96	0.02	38.6	<0.001§
CYP with mental disorders	1.41	1.31	1.51	0.04	9.2	<0.001§
Older people with LD	1.37	1.27	1.49	0.04	7.6	<0.001§
Older people with ASD	0.46	0.39	0.53	0.08	-10.3	<0.001§

† Significant with p-value<0.05; ‡ significant with p-value<0.005; § significant with p-value<0.001, ⊥Category 'not recorded' included in the model due to high number of missing values; LD= learning disability (intellectual impairment); CYP= children and young people; ASD=Autism Spectrum Disorder

The results of the logistic regression model highlighted several organizational characteristics that were significantly associated with the likelihood of BME British workers' presence in the social care workforce. British BME workers were significantly more likely to work in the private sector than for local authorities when compared to their White British counterparts (OR=1.34, $p<0.001$) and in residential care settings after controlling for other factors. While British BME workers were more often employed in organizations with medium than low turnover rates than White British workers, the magnitude of difference was not particularly large (OR=1.07, $p<0.001$) although they were significantly less likely to be working in organizations with high turnover rates (OR=0.9, $p<0.001$). On the other hand, British BME workers were more likely to be working in organizations with lower staff vacancy rates.

In terms of job characteristics, the model showed that BME British workers were significantly more likely to have professional and direct care jobs (reference category) than managerial or supervisory roles when compared to White British workers (OR=2.26, 0.80; $p<0.001$ respectively). Some BME British workers hold qualifications, especially social work and nursing, and are employed in such roles.

Work patterns

BME British workers were also significantly more likely to hold temporary contracts or to work through employment agencies than to hold permanent posts relative to their white British counterparts, highlighting possible greater job insecurity among BME workers. These findings were mirrored by findings related to working patterns, where BME British workers were significantly more likely to work on a flexible basis (OR=1.35, $p<0.001$). In relation to service user groups, BME British workers were significantly more likely to be working with older people and adults with learning disabilities, and with children or young people with mental health problems (OR-1.37, 1.90 and 1.41, $p<0.001$ respectively) than others.

Discussion

While the current study offers a unique insight into the BME British contribution to the social care sector within different organisational and local contexts , it is limited in a number of ways. First, it was not possible to capture the full impact of ethnicity, given its social construct from the data. Second, while the data allowed us to separate recent migrants from British BME staff, we acknowledge the difficulties in capturing, or separating, the impacts of migration, race and identity and gender when using pre-coded groups such as that available in measurement analysis. This is due to a number of reasons, primarily the intersectionality of these identities, rather than being an additive nature as identified by Bowleg (2008). However, the ability to separate the experience of recent migrants from workers belonging to an ethnic minority but with full citizenship rights facilitated, to an extent, the exclusion of some inherent assumptions associated with being migrant workers, for example, employer attachment and limited ability to change employer or sector especially if migrants are from outside the European Economic Area and need to hold qualifications to gain employment in the UK.

A third limitation may relate to the dataset itself. This analysis relies on the data provided by individual employers and so may not be entirely accurate. Information on ethnicity and nationality (citizenship) was not reported for all staff and this means that caution should be taken in generalizing the findings. There are also some staff who may be non UK born but who have naturalized or gained UK citizenship without the knowledge of their employers and so these may have been classified as migrants rather than BME British.

The analysis shows that the overall numbers of British BME workers in the English social care sector are likely to be considerably lower and differently profiled than that estimated previously (Hussein 2009, Skills for Care 2011). This is because this analysis has enabled the separation of British BME workers from BME workers from other nationalities who are likely to be recent migrants and to hold skills or qualifications as part of their permissions to work in the UK. British BME workers constituted 7.5 per cent of all workers reported in the NMDS-SC, June 2011, and 8.7 per cent of all British workers identified by the same dataset. Nearly 40 per cent of British BME workers were identified by employers to be of Black or Black British ethnicity and 22 per cent as being Asian or Asian British, with a considerable proportion of 30 per cent being identified as belonging to 'other' ethnic groups. Such a distribution does not reflect the overall ethnic distribution of England and Wales where the largest ethnic group is other White (5.3%) then Asian or Asian British (4%) followed by Black or Black British at 2.3 per cent and mixed ethnicities at 1.8 per cent (ONS 2012).

The high proportions of workers from Black and Black British ethnicities are not just confined to direct care jobs but are consistent with an increase in social work students from this group following the introduction of the new social work degree in 2003 (Evaluation of the Social Work Degree in England Team 2008). The relative under-representation of workers from Asian ethnicity may be related to different perceptions of social care work's low status and perceived unsuitability among Asian communities in the UK, particularly for young women (Robinson et al 2006).

British BME workers are slightly younger than White British workers; however, the two groups share a relatively high median age (early-40s). Moreover, previous research has revealed that younger workers (18-25 years) in the sector are less ethnically diverse than their older counterparts (Hussein and Manthorpe 2010), raising questions about how careers in social care are still perceived by and portrayed to young adults from different communities. Observed differences in the ethnic structure of different age groups might be linked to educational attainment among young adults, particularly among females, who constitute the large majority of care workers in England.. Making information available about different career options in the sector to young adults at secondary school level may be useful to employers seeking new staff, it will not on its own address the ambitions of young people and their parents to step away from low paid work. The analysis highlights the interesting over-representation of men among British BME workers. This may point to gender-differentials of cultural acceptance or rejection of certain jobs and poses questions whether some care jobs are regarded as requiring and rewarding physical strength and assertiveness.

The relative under-representation of BME British women within the sector in comparison to White British workers may reflect some of Robinson et al (2006) findings related to perceptions of the unsuitability of care work for women among some BME communities. Some of these variations may also be attributed to economic factors and unemployment rates; for instance, the care sector is an almost 'recession proof' sector and has the ability to absorb some labour 'spill over' from other sectors.

The analysis shows that, while similar to migrant workers in that BME British workers are over represented in registered nurse posts (Hussein 2011), they differ in terms of representation in other jobs. BME British workers are relatively more common within social work jobs. The over representation of British BME workers in professional job roles, especially social work, is consistent with recent changes in the profile of social work students (Evaluation of the Social Work Degree in England Team 2008). On the other hand, BME British workers are under represented in non-care providing roles, including administrative and ancillary jobs and are considerably under-represented in first line and middle management jobs. These findings are consistent with previous research, which identified

some ethnic-differentials in career progression in the health and social care sectors, where staff from BME groups are more likely to have slower career progression and are less represented within managerial roles than White workers (Elliot et al 2002). Previous research has shown the importance of having a 'profession', autonomy and the opportunity to make decisions in BME people's choice of careers (Greenwood et al 2006). At the same time, Robinson et al (2006) found that some young BME people regard some care jobs as 'intimate', which may pose difficulties for both BME men and women. Such perceptions and attitudes, while they may not be generalisable, may partly explain the over-representation of BME staff in 'professional' jobs such as nursing and social work. However, the data show that some BME groups are not under-represented in 'hands on' care jobs (those involving direct care), which challenges the stereotyping of such views and deserves more specific investigation.

Disability disclosure in employment is likely to be associated with levels of work autonomy and empowerment and may indicate lower confidence among BME workers to disclose their disabilities to their employers for fear of losing their jobs, for example. These differences may be related to different disclosure patterns and may be linked to empowerment and sense of security in the workplace (Ellison et al 2003). This may be especially the case given the higher likelihood of British BME workers being employed on temporary contracts or on a flexible basis. However, there may be other explanations that further research might identify.

An important finding is the apparent differentials in relation to job (in)security, related to both employment status and working patterns, between British BME and White British workers in the care sector. Significantly more BME British workers are employed on a temporary or flexible basis and are recruited through agencies which reflect the less favourable work conditions that are usually attached to these types of contracts. British BME workers are also significantly more likely to be employed in the private sector than White British workers, which is generally characterized by harder working conditions and less favourable pay levels (Hussein 2010 and 2011b, Rubery et al 2011).

Similar job security differentials are highlighted by variations in work arrangements and agency working between White and BME workers. In the care sector, the agency workforce is very diverse, ranging from experienced professionals providing managerial expertise and consultancy to part time or one off workers in care homes or domiciliary settings. Hoque and Kirkpatrick (2008) estimated that approximately half of all agency/temporary workers in English social services were professionally qualified social workers, most being employed in higher risk services for children and families with the vast majority based in London. Cornes et al (2013) recent survey of local authorities found that the majority considered agency workers as playing an important role in 'keeping the show on the road'. The same research also showed that many agency workers saw this type of working as advantageous, not only in terms of flexibility but also the opportunities for broadening their practice experiences. Evidence from research suggests that agency workers are often brought in to 'tackle' certain problems and not only to fill vacancies (Hoque and Kirkpatrick 2008, Cornes et al 2013), thus agency staff may feel under higher pressure than others. Variations in employment status may be indicative of wider and more important ethnic-gaps in relation to job security and career progression opportunities. Findings from the current analysis about differentials in turnover and vacancy rates may paint a picture of higher employment attachment among British BME than White workers, thus a higher prevalence of British BME workers may contribute to keeping both turnover and vacancy rates lower than average. This possibility could be explored by analysis of employment records over time.

The analysis of source of recruitment to current jobs indicated that the care sector appears to attract White British workers from outside care occupations more than it does in relation to BME British workers. These findings may highlight a need for recruitment campaigns to target potential applicants from diverse backgrounds thus expanding pools of recruitment, including the importance of family and friends' recommendations. This supports theories that networks are important in achieving employment in social care because people may be more likely to be attracted to the sector through personal contacts than from advertising or advice from careers' services or job advisors (Parker and Merrylees 2002). The differences exposed here in relation to source of recruitment indicate a need for greater attention in devising recruitment campaigns that appeal to and reach diverse communities. These findings chime with previous research that highlights considerable knowledge gaps about careers in the health and social care sectors among different groups of BME communities in the UK (Helm 2002, Greenwood et al 2006; Robinson et al 2006).

The finding that British BME workers are significantly more likely to have lower qualification levels and other, not directly relevant qualifications, than White British workers, combined with findings related to source of recruitment of British BME workers being more likely to be from within the care sector, may be indicative of the unattractiveness of the care sector as a career 'choice' for some British BME people. The findings indicate that the sector may attract BME people with relatively low levels of qualifications who may not be able to find jobs in other sectors. The sector also appears to attract some people who have not made a career 'choice' to join the care sector and who have gained 'other non-relevant' qualifications but end up working in the sector for different reasons. Such observations are important in devising recruitment campaigns that are attractive to different groups who may not necessarily actively seek information related to the care sector.

Conclusion

The current analysis challenges the use of overall statistics of relatively high contribution of minority groups to the social care sector as an indicator of diversity and inclusivity. It thus provides a platform to examine obscure inequalities within the sector that are associated with race and ethnicity. From a policy perspective, the current analysis highlights a need to actively address the position of British BME workers within the care sector, especially at a time where immigration policies may be restricting the recruitment of non-EEA nationals. Issues related to recruitment disparities as well as inequalities in relation to job security call for human resource strategies that are more proactive and for the vigilance of trade unions and professional groups. Efforts could be made to positively improve the image of non-professional social care jobs among different communities and to evaluate their impact. Career progression is an important factor in attracting workers to any sector; within social care efforts could be focused on tackling ethnic discrimination and ensuring all workers have equal opportunities to gain promotion. Opportunities for workers with unrelated qualifications and experiences to join this workforce could be made visible during recruitment processes, especially when approaching BME communities. At a time of redundancies among many UK employers this may be particularly relevant and new skills may improve productivity.

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NOTES

[1] Information circulated to the NMDS-SC Data User Group of which the lead author is a member

[2] Downloaded from the Office for National Statistics (ONS) website, www.ons.gov.uk)

[3] 'Predominantly Rural' areas have from 50 to 80 per cent of their population living in rural settlements or large market towns. 'Significant Rural', indicates that a district has between 26 and 50 per cent of its population living in rural settlements and large market towns. 'Predominantly Urban' areas are those with at least 50 per cent of their population living in urban centres.