JRF JOSEPH ROWNTREE FOUNDATION

REPORT

POVERTY AND ETHNICITY

BALANCING CARING AND EARNING FOR BRITISH CARIBBEAN, PAKISTANI AND SOMALI PEOPLE

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This report involved qualitative and quantitative research with low-income Caribbean, Pakistani and Somali people regarding their experiences and preferences in balancing work and care.

Existing policy on childcare and caring doesn't appear to respond effectively to this challenge, while employers need to do more to enable well-paid flexible working and eliminate discrimination in recruitment and progression.

The report finds that:

- discrimination is one of the key barriers preventing low-income ethnic minority people from balancing work and care;
- existing good practice on reducing discrimination must be strengthened and expanded across public and private sector employers;
- various benefits changes are likely to make it more difficult for many low-income ethnic minorities to balance work and care;
- there are not generic attitudes towards 'caring' within or across ethnic groups; and
- gendered expectations compromise higher labour market participation among women, while men are less likely to fulfil caring responsibilities.

MAY 2014
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CONTENTS

EXECUTIVE SUMMARY

For most people, the two most important roles in their lives are their caring relationship with family members and loved ones, and their earning relationship in the labour market. Over the past few decades more people have formally entered the labour market, while the proportion of those providing care has risen too.

These developments create challenges for those seeking to balance work and care, and are likely to continue, given underlying demographic changes and developments in the labour market.

In this research we approach this challenge from the perspective of poverty and ethnicity, considering how low-income Caribbean, Pakistani and Somali people experience work and care, including childcare. Our aim is both to understand the experiences of these primarily low-income interviewees and to identify any policy and practice changes that could improve their lives.

This research addresses three different caring scenarios: caring for children, caring for children with a disability and caring for older people. We have found that while each of these caring situations creates challenges for low-income people in accessing the labour market, there are also differences in how our research participants responded to the different caring scenarios. For example, while a Caribbean mother may be happy for her child to enrol in formal childcare, she may be less willing to see her father live in a care home with few other black residents. Alternatively, while Pakistani and Somali parents were less likely to take up formal childcare services, in part because of concerns about the cultural appropriateness of that care, those concerns were not very relevant in terms of accessing care for their disabled children.

Four themes capture the key findings of our research and inform our recommendations. The first theme is access to employment. Almost all our participants outlined concerns about access to the labour market. Many expressed these in terms of discrimination, so we have suggested a number of ways that employers and the government could improve recruitment, retention and progression for ethnic minorities, often by building on existing practices.

At the same time, many also highlighted concerns that are widely mentioned by carers generally – in particular the difficulty of finding work that they can balance with their caring responsibilities. Although our Caribbean, Pakistani and Somali participants had somewhat different experiences and views about how best they could balance work and care, our recommendations also reflect the general finding of significant demand for more flexible working and better part-time work.

Another key finding is that ethnic minority people do not have generic attitudes to 'caring' as such. This relates to a second theme: the role of cultural or religious preferences in informing attitudes to caring, and especially access to formal caring services. Among Pakistani and especially Somali respondents these considerations were particularly important in explaining the low use of formal childcare services. This appears to be related to parental emphasis on transmitting cultural values and practices to their children. Some parents would be satisfied if such care was more culturally sensitive, or if some staff shared their cultural or religious values, although a significant minority preferred to be the primary carer for their children at least until secondary school. On the other hand, almost no parents felt that cultural or religious beliefs and practices were significant in caring for disabled children, where the overriding concern was that their children had appropriate care and support.

Ethnic minority people do not have generic attitudes to 'caring' as such.

In terms of caring for older relatives, these cultural considerations also often emerged, especially where relatives were asked about residential care homes. For Caribbean people, cultural concerns generally were less pressing, although they were actually somewhat more likely to arise in relation to caring for older relatives than for children. A number of our recommendations therefore address ways that caring services might adapt culturally so that ethnic minorities have better access to those services, as well as how policy could better support caring within the family.

As important as cultural preferences is awareness or knowledge of services. Very few of our Pakistani and Somali respondents were aware of free childcare services; they also were not always certain about the support available for their disabled children and older relatives. These findings inform our recommendations on a third theme of information and advice, including advice on benefits.

This raises the fourth important theme of our research, namely the impact of Universal Credit and other benefit changes on ethnic minorities. We do not believe the government has adequately assessed the impact – or explained the relevance – of these changes on ethnic minorities, and the fact that this may result in them being worse off. This is because ethnic minorities are more likely to live in poverty, have higher rates of child poverty, and live in London (and thus affected by the benefit cap), and because some groups (including Caribbean and Somali populations) have higher rates of lone-parent households. We suggest a number of ways that policies could be improved, and areas where the government needs to think harder to ensure that ethnic minorities are not further disadvantaged by these changes.

Our analysis considers the opportunities and constraints that inform the choices people make in balancing work and care. However, we have also found that people's beliefs and values – in particular their feelings of obligation to family members – are often as important in framing their decisions. In our recommendations we therefore aim both to enhance the opportunities people have to balance work and care and to suggest solutions that respond to people's actual needs, preferences and values. While some of our policy recommendations are universal in nature, a number of them

are targeted, as evidence suggests that many policies do not properly understand or respond to the needs and preferences of ethnic minorities, and thus risk making ethnic inequalities even worse.

Recommendations

Theme 1. Access to employment

Recommendation 1. Data on ethnicity should be better collected among employers, including in the hiring, progression, disciplinary and redundancy processes, and should be segmented by seniority and wages.
Recommendation 2. Employers should adopt various policies to improve the representation of ethnic minorities in hiring and progression. Among those already known to work are:

- including at least one ethnic minority on interview panels – if this is not possible internally, the employer should consider training external experts to interview for the organisation;
- adopting unconscious bias training;
- making more and better use of positive action.

Recommendation 3. Employers should support more flexible working. Policy-makers should consider how they can better support flexibility, especially for carers, including by monitoring how far employers actually offer flexibility when employees request it. There is also a case for considering sabbaticals and longer leave policies, even if unpaid.
Recommendation 4. There should be more English for speakers of other languages (ESOL) funding to improve employability among the tens of thousands of men and women who would like to get work and improve their English, but presently have limited opportunities to do so, including through (but not limited to) Universal Credit.

Theme 2. Information and advice

Recommendation 5. Better information is needed on childcare options. Too many ethnic minority parents are not aware of free provision in particular, and there should be a push by local authorities and perhaps health providers to inform parents of the 15 free hours of early education for 2- to 4-year-olds.
Recommendation 6. The cognitive and behavioural benefits of childcare should be better promoted. Ethnic minority parents highly value education, and would perhaps be more likely to take up childcare if they were more explicitly told that it is 'early education', and if they had better knowledge of its benefits.
Recommendation 10. Public bodies and other relevant institutions (including employers and schools) should do more to combat discrimination and stigmatisation on grounds of disability. There is a need for sensitive work in some ethnic minority communities to raise awareness about disability, and also for targeted support to parents with disabled children where their social networks are less supportive.
Recommendation 11. Ethnic minorities need greater awareness and knowledge of Carer's Allowance, as it is not well understood generally, and is likely to have poor uptake among those ethnic minorities entitled to it. There should also be further work to ensure older ethnic minority people are receiving any qualifying disability benefits to which they are entitled.

Theme 3. Improving access to formal care services

Recommendation 7. More ethnic minority women should be trained as childminders. With more ESOL funding this training could be much expedited, and councils could consider allowing those with more limited English to care for children if parents agreed, where those parents do not speak English themselves, and where the childminders have completed a certain level of training.

Recommendation 8. Further research and practice is needed on improving the supply of childcare generally, and for sessional or irregular childcare hours in particular. This is particularly relevant for ethnic minority groups who often work irregular, night or weekend hours (e.g. in restaurants or hotels or as taxi drivers).

Recommendation 12. Care homes should provide care that better caters to the needs of ethnic minorities. This could include ethnic-specific care homes, more diverse meal choices (at least on a weekly basis), more training of care workers, more diverse television and cultural offerings, or partnering with local restaurants to provide low-cost meals to particular ethnic minority communities.

Recommendation 13. Ethnic minority young people should be targeted for training to gain the skills to be carers, including foreign language skills. Given the low wages and poor progression routes in caring professions, and the already high concentration of ethnic minorities in these kinds of job, the focus should be on skills that are transferable to other jobs, such as foreign languages or 'soft' interpersonal skills, which are valued by a range of employers.

Recommendation 14. For personalisation to be a reality, and for care markets to function effectively, more innovative solutions are needed. In particular, smaller community-led providers should be encouraged to work together, perhaps under brokerage services, so that people receive appropriate and personalised services, and so that the supply side of care markets is sufficiently developed. One key set of institutions local authorities should consider supporting in this way is those community organisations with the best track record of supporting ethnic minority older and disabled people.

Theme 4. Ensuring existing policy is fair to all

Recommendation 9. Special Educational Needs Assessments should be checked to ensure they are adequately assessing and addressing needs in ethnic minority families. This will require further engagement with ethnic minority parents, and at times include a translator.

Recommendation 15. The government should rethink Universal Credit in various ways so as not to worsen outcomes for ethnic minorities and other disadvantaged groups.

- The government should reconsider its payment of Universal Credit to households only, and instead transfer at least a portion (say 25 per cent) of the non-housing element to every adult household member. In most cases, payment will be to the male head of household, undermining women's independence and financial inclusion, and reducing their capacity to escape domestic violence. Ethnic minority women are particularly vulnerable to these changes, while international evidence indicates that mothers are more likely than fathers to spend money on children, suggesting that the already high child poverty rates among ethnic minorities may rise further still.

- The government must monitor the effects of Universal Credit by ethnicity. In particular, it must monitor how many ethnic minority women move from economic inactivity into work, and how many families drop out of the welfare system entirely.
- The government must introduce changes to ensure that Universal Credit does not disadvantage and make it harder to balance care and work for single-parent families. Two possibilities are increased childcare support for such families, and greater work incentives under Universal Credit.
- The impact of benefit changes needs to be better explained to groups who are less likely to take up benefits to which they are entitled, and less likely to be aware of upcoming changes. This includes a communications plan for ethnic minorities, targeting community centres, churches, mosques, ethnic and local media, as well as GPs.

Recommendation 16. The government should consider further and aim to counteract how changes in benefit policies – particularly the benefit cap and changes in how childcare is supported under Universal Credit – will affect childcare among ethnic minorities. For example, the Department for Work and Pensions (DWP) has suggested that 40 per cent of those affected by the benefit cap will be ethnic minorities, which may encourage them to move away from family members who currently provide childcare support and allow parents to work (or to work more hours). This should involve showing data not only on the effects on ethnic minorities but also on how existing policy might counteract these effects and address ethnic inequalities in Britain.

1 INTRODUCTION

The relative disadvantage of the UK's black and minority ethnic population in terms of health status, longevity and material resources is well documented (Li and Heath, 2008; Victor, *et al*., 2012; Nazroo, 2001; Mawhinney, 2012; National Equality Panel, 2010; Platt, 2009a; Khan, 2010). However, there remain gaps in our evidence base with regard to understanding the causes and consequences of black and minority ethnic people's greater incidence of poverty.

For the general population, caring responsibilities for older people or for children with disabilities are linked with compromised employment opportunities, reduced pension entitlement and poverty/low income (Carers UK, 2009). Results from the 2001 and 2011 censuses indicate that the extent of caring is higher among black and minority ethnic populations. A particularly important factor for all ethnic groups is the effect that these caring responsibilities have on employment and general well-being (Barnard and Turner, 2011), but this relationship remains unclear. We hypothesise that this works in at least three ways: various barriers may prevent black and minority ethnic people from balancing caring and work in the ways they wish; caring responsibilities may act as a barrier to work; or, alternatively, work may be viewed as a barrier to caring.

This research responds to wider social trends affecting the nature of work and care for everyone in the UK. Notably, women are more likely to provide caring support, while the rise in the number of women working has been the main driver of increasing labour market participation. Previous research has referred to these trends in terms of supply (more women are at work, and so cannot care full time) and demand (people live longer and are more likely to need care) (Hirsch, Phung and Manful, 2011).

While the three caring situations we explore raise distinctive issues, this research explores three key considerations that connect them: the link with poverty and disadvantage; access to and engagement with health and social services; and the relevance of 'ethnic matching' in the development

and provision of services to support carers – e.g. the development of specialist care homes, a preference for a carer from the same ethnic group or specialist nursery/childcare support. Examining three different caring situations enables us to explore whether people have different attitudes regarding different kinds of caring situations. For instance, Caribbean people may be happy to enrol their children in statutory nurseries but less comfortable to place their older parent in a care home with few other Caribbean residents. In this case, people do not have generic attitudes to 'caring', but respond differently depending on their situation, age and perhaps place of birth.

We consider when and how ethnicity is a factor in different caring situations, and the extent to which this influences people's choices and their opportunities in the labour market. Some of the key issues we address are discrimination, gender, cultural or religious preferences and access to services, as well as the ways these experiences influence choices and opportunities and ultimately how Caribbean, Pakistani and Somali people balance work and care.

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Our participants' experiences suggest various policy agendas this report seeks to inform. First is employment policy generally, including Universal Credit and its key aim to improve incentives to 'make work pay'. Second is childcare, including the increasing recognition that the cost of childcare in the UK is too high, and the resultant challenges for those seeking work. Third are welfare reform changes, including those affecting carers for disabled children. Fourth are policies around caring and social care.

Following this introduction, the next chapter explains our research methodology. In Chapter 3 we outline the background to this research, particularly the migration, employment and caring experiences of Caribbean, Pakistani and Somali people in the UK. Chapters 4–6 report the key findings of our research, focusing on childcare (Chapter 4), care for young disabled people (Chapter 5) and care for older people (Chapter 6). We conclude with a final chapter that links these findings to wider policy debates and offers recommendations that could enable Caribbean, Pakistani and Somali carers to navigate their opportunities, overcome barriers and ultimately make choices to better balance caring and work.

2 METHODOLOGY

This research used a variety of methods. These included five elements, combining quantitative and qualitative methods, and involved the analysis of existing data as well as the collection of primary data.

The first element was a desk-based literature review. The second and third were based on recently completed research by Brunel University, namely a 1200-person survey on informal care among black and minority ethnic people in the UK, and 60 related qualitative interviews on the same topic. In both cases the Brunel team reanalysed their findings in line with this project's research questions. The fourth element was new qualitative interviews on childcare, including a small sample of those caring for disabled children. We interviewed around 15 people each in the Caribbean, Pakistani and Somali communities. The research was managed by the Runnymede Trust, the UK's leading race equality thinktank, with the lead author also based at Runnymede.

Our final research element was three further focus groups. The purpose of the focus groups was to test our interim findings. In the case of two of the focus groups, our concern was to test the representativeness of our findings among the Pakistani and Somali communities, as our findings suggested very few women worked or took up childcare. We therefore interviewed experts or members of these communities who did not take part in the interviews and deliberately asked if our findings so far resonated with their experiences. Our final focus group was conducted with policy experts and had a similar purpose in terms of testing our initial findings, but was also forward-looking in raising various policy recommendations that the research might suggest.

The research focused on three ethnic groups living in the UK: Pakistanis, Caribbeans and Somalis. Each group has a higher incidence of poverty than average. In large part this is because of worse outcomes in the labour market, including unemployment and low-paid work. Whatever challenges arise for carers on low incomes are likely to be prominent among these groups.

Previous research further suggests that these groups have distinctive characteristics or attitudes regarding caring. Pakistanis tend to share with other South Asian groups a preference for family-based caring, while

Caribbean groups are often those most willing to take up formal services. Among the other largest ethnic minority groups in the UK according to the 2011 census (Indian, Bangladeshi and Black African), the other South Asian groups do not differ as much from Pakistanis in terms of cultural or other preferences for family-based or informal care. Based both on their numbers and their likely differing experiences and preferences to Black Caribbean and Pakistani people in the UK, we decided that the Black African group would add the most to our research design and meet methodological requirements in terms of numbers and distribution. However, the Black African group is extremely diverse. We studied Somalis because they have high rates of poverty, are contained in significant numbers in our existing research and are a more recent migrant group. We can also compare whether Islam as practised by Pakistanis and Somalis has a different (or any) impact on attitudes to caring, whether for children, older or disabled people.

One of the assumptions in our research was that people may not have attitudes towards 'caring' generally but may rather have different needs and preferences in various caring situations. That is, while a Caribbean mother and father may be very happy to have their child looked after in a local authority nursery, the same individuals may have different expectations when it comes to care for an older parent.

People may not have attitudes towards 'caring' generally but may rather have different needs and preferences in various caring situations.

To test this assumption, we asked people about their views and preferences in different caring situations. We analysed Brunel University's and Runnymede's previous (2010–2012) work on older ethnic minority people, which posed four main questions: what kind of care do people give or receive; what is their knowledge of and uptake of care services; what barriers prevent uptake of services (and more specifically, is 'culturally appropriate' or 'ethnic matching' relevant for their needs); and how do they balance earning and caring?

In terms of geography, we worked only in London, given time and budget constraints. Our existing research portfolio extends across England, and some of Brunel University's quantitative data and Runnymede's previous research used in this report therefore extends beyond London. In thinking about the links between local labour markets and caring outcomes, we have also found that experiences in London vary significantly. Fieldwork took place in three different London boroughs, allowing us to consider how access to and opportunities for work affect caring choices in these locations.

Research aims and questions

Given the gaps in existing evidence this project aims to understand black and minority ethnic people's experience of caring, and how this relates to their experience of work via the following specific research aims:

- to investigate the factors that facilitate (or act as barriers to) employment in relation to three different aspects of caring: childcare, caring for older people, and caring for disabled children;
- to examine the similarities (and differences) in these factors between three ethnic groups known to have high levels of poverty/material disadvantage;
- to consider whether income and other socio-cultural factors influence people's caring choices;
- to determine whether differing ethnic groups understand and take up care services, and to appreciate any differences in knowledge of and attitudes to the three caring situations.

Further explanation of research elements and analysis

This section further elaborates the five research elements. Our scoping exercise involved a comprehensive review and evaluation of existing empirical data sources, a literature review and the generation of a secondary data analysis strategy. This consisted of desk-based research, and the literature review and data analysis form part of the analysis throughout this report, especially in the background chapter.

The second main element in this research was a quantitative analysis of a currently unpublished survey undertaken by Brunel researchers, which explores the provision and receipt of informal care across generations (40–64 and 65+) and six key black and minority ethnic groups (Black African, Black Caribbean, Chinese, Indian, Pakistani and Bangladeshi). This survey of 1200 people enabled us to capture information on the diversity of caring, and included measures of employment and income.

The third research element was a re-analysis of 60 qualitative interviews also undertaken by Brunel University, conducted with the six populations and two generational groups, focusing specifically upon issues of employment and caring. Runnymede supplemented these elements with our findings from our 3-year programme on financial inclusion among black and minority ethnic older people.[1]

A fourth element was new primary research, consisting of data collection on childcare and caring for disabled children in Pakistani, Caribbean and Somali families. This included face-to-face interviews with 42 people across the three ethnic groups:

- 42 (15 Pakistani, 14 Caribbean, 13 Somali) interviews on childcare provision. All participants were over 24. Questions addressed financial concerns, work, cultural concerns, and uptake and knowledge of existing provision.
- 10 interviews (4 Pakistani, 3 Caribbean, 3 Somali) with families caring for a disabled child or adult. Our numbers are smaller here because of the difficulties of accessing large numbers and because our aim is to provide a detailed description of the families' experiences. The families were also included in the interviews on childcare above.

All interviews were recorded and transcribed, with translated interviews following a strict protocol. We used thematic analysis and a grounded theory approach to analyse the findings.

Our last research element involved three focus groups. Following initial analysis of our interviews, we conducted three focus groups to test our interim findings as we recognised that our sample might not be wholly representative. One of these was an 'expert' or 'policy' focus group to ensure our research questions and analysis fitted the wider policy context and to consider any policy recommendations. Our other two focus groups (15 participants in total) were within the Pakistani and Somali communities or with people who worked with those communities on childcare and disability. We did this both to boost numbers and to test the representativeness of our sample. The Somali focus group was primarily conducted in Somali and translated into English. All focus groups were recorded and coded.

Other methodological issues: defining our concepts

The various concepts and policies we discuss in this report are subject to disagreement regarding their definition and significance. For ethnicity, we have used census categories generally, meaning that we have often had to use the 'Black African' category for Somali outcomes, except where we have estimates for Somalis specifically. The census categories are not only familiar but also those used by other researchers and public bodies.

We also adopted standard definitions of such concepts as poverty, employment, unemployment and inactivity. For poverty we have used the standard definition of 60 per cent of median income, while our employment data is based on the International Labour Organization (ILO) definition found in the UK Labour Force Survey and census. These definitions are widely recognised in the UK and are again used both by researchers and the government.

However, on the issue of 'caring' the question of definition is somewhat more contentious. There is less agreement about what constitutes caring, whether existing survey questions accurately reflect respondents' caring roles, and how to define 'informal' care. We discuss these issues as necessary in the chapters below, but elaborate somewhat on this point here to aid exposition in those chapters, and as these issues are not fully resolvable.

There is significant debate about the reliability of data on caring, and particularly the implied links with the physical nature of caring, especially as people's understanding of caregiving appears to vary significantly. The General Household Survey question and its successor surveys require respondents to compare their activities against some hypothetical norm and then to define or contrast their 'caring' activities as 'abnormal' or outside of 'normal' spouse, sibling or filial (or other relationship) roles. This definition may lead some people to over- (or under-) report their family responsibilities as caring. For example, this definition is likely to be gender biased: women under-report what they do as caring, while for men the opposite may hold. There may also be differences in how this question is answered in terms of age, class or ethnicity, although these aspects have been less well investigated. A key issue of debate is whether participants can differentiate caring from 'normal' family relationships and responsibilities.

A key issue of debate is whether participants can differentiate caring from 'normal' family relationships and responsibilities.

The concept of care in the major surveys represents a limited task-orientated 'caring for' that emphasises the 'exceptionality' of caring – focusing upon responsibilities over and above what is considered normal. This may not fully capture the extent to which caring activities form part of daily life within ethnic minority communities where family care is an expectation and is therefore considered 'normal' (see Phillips, 2007). Ahmed and Jones (2008) have described the experience of Bangladeshi women carers aged 35–55, while Baldock (2000) looked at the issue of migrants in mid-life returning to look after older people in their 'home' country. There is also research on the support needs and experiences of informal carers in contact with services (Katbamna, *et al*., 2004; Adamson and Donovan, 2005; Merrell, *et al*., 2006) and the relationships between informal and formal care services (Sin, 2006). However, as with the rest of the population, such individuals represent only a small number of carers and are probably not fully reflective of the range of caring situations, the expectations and experiences of giving and receiving care, and the diversity of the ethnic minority communities.

Different approaches define and put into practice the concept of informal caring in research that aims to enumerate the extent and nature of informal care. Parker (1981) distinguishes between 'caring about' – concern for the

individual and their welfare – and 'caring for' – a focus on direct 'hands-on' help – which has also been conceptualised as 'tending'. This typology raises the interesting but not entirely resolved question: is caring about an individual an essential pre-requisite to caring for them?

Various typologies of caring focus on the nature of the caring relationship rather than the delivery of physical activities or other types of task. For example Matthews and Rosner (1988) identify five types of what they refer to as 'helping patterns': routine help; back-up help; circumscribed help; sporadic help; and finally 'dislocation', which occurs when a child cannot be counted on to help. Nolan, *et al.* (1995) have developed an eight-stage temporarily framed typology, which starts with anticipatory care and concludes with reciprocal caring. Such typologies offer new insights on caring by addressing the dynamics of the relationship, but have not been used empirically to count carers because of the difficulty of putting these definitions into practice.

The search for a simple definition that distinguishes carers from non-carers may be fundamentally elusive: caring – like chronic disease and disability – forms a continuum of relationships between an individual and their family/social network, and where to draw the line in such a way to fit every circumstance is obviously not straightforward.

We generally deferred to our research participants in terms of how they wished to self-identify, whether as carers or not. Although we have sought to reflect participants' individual voices and experiences, we have also reported on how caring is perceived or managed in families and communities. While we interviewed more individuals who have tended to spend more hours caring for family members than in paid employment, some participants were in full-time employment, and all participants personally understood our research focus on the challenges of balancing work and care, whether or not they self-identified as a carer.

Ethical issues

The research previously analysed by Brunel researchers already met Brunel University and Economic and Social Research Council (ESRC) requirements for ethics, and both parties to this research application adhere to Social Research Associations' (SRA) guidelines. The most pronounced ethical issues that could have arisen in this research are those of abuse. We certainly did not anticipate that our interviewees would abuse those they care for. Nevertheless, we are aware that abuse can occur and so we required interviewers to report any suspicions to project leaders.

Other ethical issues we considered related to migration status and benefits uptake. We probed these areas sensitively, and more generally were aware of raising anxieties among participants. We value participants offering to share their experiences, especially on sensitive subjects, and believe an incentive payment is a minimal appropriate response to their participation. We hope that this research report satisfies participants that their experiences are accurately represented, and further that the recommendations in this report have some impact on policy to improve their lives.

3 BACKGROUND

In this chapter we outline the backgrounds of the three main communities in this research, including their experiences of working and caring. Building on the framework suggested in the introduction, these experiences are important for shaping the choices people make in terms of caring and working, particularly the opportunities or constraints that frame those choices.

The historic background: Caribbean, Pakistani and Somali communities in the UK

The three communities involved in this research have different histories of migration to the UK, different demographic characteristics, different preferences in terms of caring and work, and different outcomes in the labour market. In other words, Black Caribbean, Pakistani and Somali communities have different opportunities and constraints affecting their attitudes and choices regarding work and care.

Black people have been living in the UK since at least Roman times,[2] and enough lived here in the Elizabethan period (late sixteenth century) for the Queen to complain about the presence of 'blackamoores' to the Lord Mayor of London. But while the black population reached perhaps 10,000–20,000 around 1750, it declined somewhat thereafter (Fryer, 1984), and the current Black Caribbean population of nearly 600,000 is mainly related to postwar migration starting from the arrival of the MV *Empire Windrush* 65 years ago in 1948 (see Phillips and Phillips, 1998).

By 1957 the Caribbean population had reached nearly 100,000, and it remained the largest ethnic minority group in the UK until the 1970s. The relatively slow growth of this population since 2001 is based on three factors: lower migration, more children born with 'mixed' backgrounds, and a shift away from self-identifying as 'Caribbean', with a preference for 'Black British' or even 'Black African' instead (especially among the young). For example, the second fastest growing group between the 2001 and 2011 censuses (and the youngest non-mixed group with a median age of 23.7) was 'Black Other'.

While there have been small numbers of people from what is now Pakistan living in Britain since colonial contact in the eighteenth century, the numbers were smaller than for black people. The present population of British Pakistanis also dates from the postwar period, although around a decade or two later.

Pakistanis are now the second largest ethnic minority group in the UK (after Indians), at nearly 1.13 million people. They are also somewhat more dispersed than the other large ethnic minority populations, with a smaller proportion living in London and more living in towns such as Luton, Oldham and Bradford. They arrived in some of these places to work in factories and through 'chain migration', whereby relatives or acquaintances in nearby villages in Pakistan helped one another move, find work and accommodation (Anwar, 1979).

Unlike Pakistani and Caribbean people living in the UK, Somalis have only lived here in significant numbers since the 1990s. In terms of official figures, including the census, Somalis are counted within the 'Black African' ethnic category, which doubled in population between 2001 and 2011 to 990,000 people and is now larger than the Black Caribbean group.

A significant experience of Somalis is that their route of migration was primarily as asylum seekers or refugees, and this continues to shape their experience in Britain, particularly in terms of labour market participation. The civil war in Somalia is still ongoing over two decades after it began in 1991, although circumstances appear safer in 2013 than in previous years, at least according to some of our respondents. In total, just under 60,000 people from Somalia claimed asylum in the UK between 1993 and 2008, with a peak of around 7,500 in 1999. These figures exclude dependants (i.e. children).

In the 2011 census, 101,000 people reported being born in Somalia, while Office for National Statistics (ONS) data on registered births shows 53,000 births in the UK to mothers born in Somalia between 2002 and 2011.[3] There are therefore at least 154,000 Somalis in the UK, and we estimate a total population around 200,000, with roughly two-thirds living in London (see also Harris, 2004).

Work and poverty among Caribbean, Pakistani and Somali people in the UK

This research focuses on how low-income people in particular balance work and care. The three communities we interviewed are among those with a higher prevalence of poverty in the UK, and each also faces challenges in the labour market. All ethnic minority groups have higher poverty rates than the white rate of 20 per cent. These range from 30 per cent for Indians and Black Caribbean people to 70 per cent for Bangladeshis (see Table 1).

Table 1: Poverty rate by ethnic group

Ethnic group	Poverty rate
White	20%
Indian	30%
Black Caribbean	30%
Black African	50%
Pakistani	60%
Bangladeshi	70%

Source: http://www.poverty.org.uk/06/index.shtml.

As this table indicates, Black Caribbean, Somali (within the 'Black African' category) and Pakistani people have high rates of poverty. All ethnic minority groups are more likely to live in poverty across all age groups, and the gaps between the white British and ethnic minority groups are bigger for most populations when housing costs are taken into account. This is partly driven by the higher proportion of ethnic minorities living in London, where housing costs are high, and partly because of the differing housing tenure among most ethnic minority groups. Table 2 below indicates that these outcomes vary for different ethnic groups, and that black African people (including Somalis) are the group most affected by the cost of housing (see Platt, 2009a).[4]

Table 2: Poverty rates for children and adults by ethnic group, before and after housing costs (% living in poverty)

	Children		Adults	Poverty rate
Ethnic group	Before housing costs	After housing costs	Before housing costs	After housing costs
White British	19	26	13	17
Indian	30	34	20	23
Pakistani	53	57	48	55
Bangladeshi	64	73	54	65
Black Caribbean	30	39	22	29
Black African	37	57	27	43

Source: Platt (2009a)

For many people work is a route out of poverty. However, racial inequalities in the labour market are perhaps the biggest driver of racial disadvantage in the UK. Ethnic minorities have lower employment rates and higher unemployment and inactivity rates than the white British population. The ethnic minority 'employment gap' (the gap between the ethnic minority and the overall employment rate) is 11 per cent, while only Indian households have lower unemployment or workless rates than white British households. Around one-quarter of black African and Caribbean working-age adults are unemployed, with the Pakistani figure only slightly lower; this compares to 16 per cent of white British working-age people.

While the employment gap has improved somewhat since the late 1990s, it is not very different from what it was in the 1980s. Furthermore, the unemployment rate for young (16–24) black men is 50 per cent, while

ethnic minorities also have lower wages than the white British population (see hourly and monthly calculations in National Equality Panel, 2010).

As a result of these worse labour market outcomes, the majority of Pakistani children are living in poverty, as are half of in-work Pakistani households.[5] Somalis are probably doing no better than Pakistanis, although the data is for black African people generally (with Somalis around 20 per cent of that population). Black Caribbean people are doing somewhat better, although they still have higher child poverty and in-work poverty rates than white British people.

Higher rates of in-work poverty are partly explained by low wages, which are in turn explained by the kinds of job or kinds of sector in which ethnic minorities work. More specifically, black and minority ethnic people experience a particular type of what economists call 'labour market segmentation', meaning that they are more likely to work in jobs and sectors where pay tends to be low. For example, 1 in 7 Pakistani men in employment works as a taxi driver or chauffeur, compared to only 1 in 100 white British men.

Many of the jobs with a higher proportion of ethnic minority workers also offer more insecure work, with unsociable hours or hours that make it difficult to find care arrangements. For example, 1 in 3 Bangladeshi men work in catering (e.g. as waiters and cooks in the late evening), while Pakistani taxi drivers and chauffeurs experience a high degree of less predictable shift and night work. This also contributes to higher rates of self-employment, and low median hourly wages (£7.74), with 42 per cent earning less than £7 per hour. Pakistanis are most likely to be earning the minimum wage (11 per cent), although black workers are less likely to do so (Low Pay Commission, 2012), perhaps because a higher proportion of black people work in the public sector.

Among both men and women, Black Caribbean people are more likely to work in public services – for example, in health or transport – with nearly half (49 per cent) of Caribbean women in full-time employment working in the public sector (see Platt, 2007). A majority live in London, with the largest populations in the London boroughs of Brent, Hackney, Lambeth and Lewisham (Jivraj, 2012). Around half of Caribbean people now own their homes, although this is still lower than the 68 per cent national average, and a greater proportion (41 per cent) also live in social housing than the overall population (17 per cent) (DCLG, 2008).

Black women, especially Caribbean women, are the most economically active of all women, although they are also most likely to be in poorly paid work with unsocial hours. Palmer and Kenway (2007) found that differences in age, family type and family work status account for half – but only half – of the higher income poverty rates of ethnic minorities. Of these three factors, family work status was most significant for Pakistanis (i.e. the high proportion of working-age adults, particularly women, not in work), while family type was most significant for Caribbean families (i.e. the proportion of lone parents), with black African excess poverty rates explained by both these factors. As the three factors together at best account for half of the excess poverty rate for ethnic minorities, a significant 'ethnic penalty' – at least partly the result of discrimination – remains. Poverty and inequality also affect social mobility, suggesting that ethnic minorities in Britain will struggle to improve their life chances. In other words, discrimination and poor labour market outcomes are significant constraints affecting ethnic minority people's ability to balance work and care; they were regularly mentioned by our interviewees.

Differences in age, family type and family work status account for half of the higher income poverty rates of ethnic minorities.

Another relevant factor in discussing caring and earning (and poverty) is the high labour market inactivity rate of Pakistani (65 per cent) and Somali (87 per cent) women; this compares to 29 per cent for women overall. There is a higher prevalence of caring among both groups of women, although Pakistani women also have the highest unemployment rate (20 per cent) of any ethnic group. At nearly three times the white British female unemployment rate, this suggests that even when they seek work Pakistani women are unable to secure it, and this may plausibly lead to 'discouraged workers', who then become economically inactive rather than actively seek work. The figures for Somalis are somewhat less reliable given sample sizes, but it is notable that up to 62 per cent of Somali men are economically inactive, compared to only 17 per cent for men generally.[6]

Here it is worth noting that asylum seekers cannot work in the UK unless and until they are formally granted refugee status. This raises the important question of why people are inactive or unemployed. For Somalis, legal ability to work is obviously an initial barrier to their labour market participation, and remains so until they are granted either refugee status or leave to remain in the UK. Being economically inactive has longer-term effects on labour market outcomes, which probably explains some of the poor labour market outcomes for Somali people in the UK. A recent study by Swedish economists suggests that being unemployed for only 9 months is equivalent to losing 4 years of experience.[7]

In addition to labour market segmentation and migration status,[8] two further common explanations for the worse labour market outcomes among Caribbean, Pakistani and Somali people in the UK are discrimination and low qualifications. Research suggests that ethnic minorities continue to experience discrimination in the labour market, perhaps most notably a DWP report (Wood, *et al*., 2009) that found that CVs with foreign-sounding surnames were twice as likely to be rejected for an interview as identical CVs with more traditionally British-sounding surnames. These discriminatory practices obviously affect Pakistanis and Somalis, given their surnames.

For Pakistani and Somali women, barriers to the labour market appear particularly significant. Employers appear less willing to hire women with headscarves, and a recent report found cases of women removing them for job interviews, and changing their names on job applications (APPG, 2013). This context is important for thinking about the interaction between caring and earning, and came up consistently among our interviewees.

Black people in the UK also experience discrimination in the labour market. Tests on 'unconscious bias' have found that black people are less likely to be viewed as having higher skills, and so have limited opportunities in terms of recruitment and progression. While it is true that newer migrants sometimes have lower qualifications, that explanation seems of limited relevance for UK-born ethnic minorities. For example, the increasing population of British-born Black Caribbean (and indeed other ethnic minority) people are now more likely to attend university and have higher aspirations than both their parents and their white British counterparts. However, British-born Caribbean men are more likely to be unemployed than their foreign-born fathers, and their wage levels are also lower (Heath and Cheung, 2006; see also Heath and Li, 2008; Machin, Murphy and Soobedar, 2009). For at least six quarters in a row (to Q4 2012), the unemployment rate for young (16–24) black men has been 50 per cent, while ethnic minority young people are much less successful in getting apprenticeship (being 26 per cent of applicants, but only 10 per cent of apprentices).

While it is good that Black Caribbean people strive for jobs in professions and in more diverse sectors than their parents, their parents' employment

in the public sector may have been more secure and afforded relatively generous pensions (Mawhinney, 2010). The relatively higher unemployment rate among British-born black men suggests a final reason that explains ethnic minority labour market disadvantage: social networks. Social networks are often important for learning about what steps people need to take to position themselves for jobs, or even to hear about job openings. As a recent report indicates, ethnic minorities may have strong social networks, but these are not always diverse or broad enough for those networks to yield sufficient advantages in the labour market (McCabe, *et al*., 2013). For most ethnic minorities, labour market segmentation, discrimination, poor qualifications and social networks remain significant barriers to better labour market outcomes.

In addition to discrimination and migration status, another barrier for some Somalis and Pakistanis in accessing the labour market is language. In general, more recent migrants are less likely to speak English well enough to gain employment, or employment commensurate with a person's qualifications. Language skills among Somali refugees and more recently arrived Pakistani women varies significantly, and many more speak basic English than do not speak English at all. While the 2011 census found that around 4 million people spoke a language other than English as their main language, it also found that only 138,000 could not speak English at all. In the census, Polish was by far the most common non-English language, with 546,000 speakers, with Punjabi and Urdu roughly tied in second place (with 273,000 and 269,000 speakers respectively). Somali was only the fifteenth most common main language (behind French, Portuguese, Spanish and Italian, as well as Bengali, Arabic, Tamil and Turkish), with 86,000 speakers. This suggests that over 40 per cent of Somalis in Britain speak Somali as a first language.

Although migrants often have strong qualifications, these may not be recognised by UK employers. The fact that many high-skilled migrants work in low-skilled jobs has been referred to as 'deskilling' and is a common phenomenon across the world, not just in Britain. However, some migrant groups appear to have lower qualifications, with 50 per cent of Somali-born migrants having no qualifications and only 3 per cent holding higher education qualifications.[9]

Age and family household profile

So far we have outlined the labour market experiences of black and minority ethnic people, particularly Caribbean, Pakistani and Somali people. These experiences are obviously of relevance in understanding the opportunities and barriers shaping people's choices in terms of balancing care and work. In this subsection we outline how black and minority ethnic people in the UK vary in terms of their demographic and household composition in ways that impact their caring.

All ethnic minority groups have a younger age profile than white British people. While the 2011 census shows that the median age for white British people in England and Wales is 42.5, it is 40.7 for black Caribbean people, 28.0 for black African people and 25.8 for Pakistani people (and only 16.6 for mixed white and black African people). As these figures indicate, the UK's black Caribbean population is notable for its (relative) ageing compared to other ethnic minority groups. While the average black Caribbean person is still younger than the average white British person, 14 per cent of the total population is over 65, compared to only 4 per cent for Bangladeshis and

Pakistanis, and just over 2 per cent for black Africans; the comparable white British figure is 19 per cent. These figures for black Africans are likely to reflect the situation among Somalis, not least given their recent migration and relatively larger families, among whom very few are over 65.[10]

This data is obviously relevant to caring for older relatives in the UK, with the issue much more prominent for black Caribbean people than for Pakistanis and Somalis. This will obviously change significantly in the coming decades, and in previous research we suggested that the number of ethnic minority people over 65 would increase from the 230,000 recorded in the 2001 census to 2.7 million by 2051 (Lievesley, 2010). Around 15 per cent of the black Caribbean population will be over 65 in 2051, compared to 12 per cent of Pakistanis and 13 per cent of black Africans.

We have already indicated that one reason for the relatively slow growth in the numbers of black Caribbean people is that younger people may self-identify as 'black Other', and another is that around half of all black Caribbean parents are married to people from a different ethnic background. In the last few years more people have been born with one black Caribbean and one white parent than have been born with two black Caribbean parents (see 2011 census age data for 0- to 4-year-olds). This development will obviously affect the age profile of the black Caribbean population, although perhaps somewhat artificially, in that many of the future older black Caribbean people will indeed have grandchildren living in the UK to support them, but those grandchildren will have a different ethnic identity.

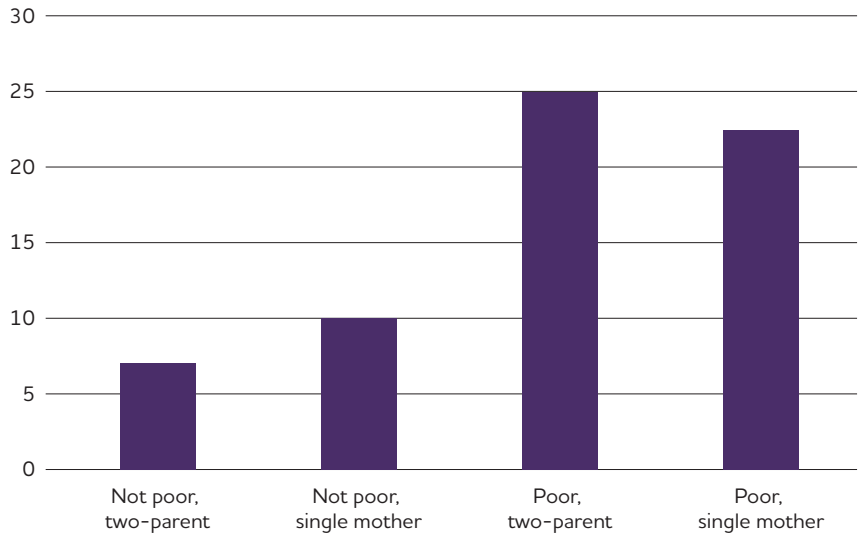
In addition to age profile, household composition varies significantly among ethnic minority groups. Black Caribbean households are the most likely to be headed by lone parents; Somalis also appear to have high numbers of lone-parent households but Pakistanis have comparatively few. Around 65 per cent of black Caribbean children live in lone-parent households, compared to 44 per cent of black African, 23 per cent of white British and 15 per cent of Pakistani children (Platt, 2009b).

In addition to age profile, household composition varies significantly among ethnic minority groups.

This greater prevalence of single-parent households should not be taken to mean that a lone parent (typically a mother) has no support from other adults, including her partner, but it does mean such support can be less secure and reliable, and partly explains the high engagement in the labour market and high use of formal childcare among black Caribbean women. Two further caveats about the prevalence of lone parents among black Caribbean and Somali families are necessary.

First, research suggests that the main causal explanations for poverty in families are economic. When people are poor at the age of 14–18 before they have a child, they are likely to be poor after they have a child too, and this is true even for those in two-parent households. More specifically, US evidence shows that only 10 per cent of single mothers who were better off before they had their children were poor as adult mothers, while 25 per cent of those in two-parent families who were poor before they had their children were still poor afterwards, despite the presence of a second parent (Figure 1). That is, single mothers can escape poverty, but mainly if they were already better off, while living in a two-parent household does not appear to offer greater protection against the risk of poverty if parents were poor before having children (see also Furstenberg, 2008).

Figure 1: Percentage of adult mothers in poverty, by poverty and family structure when they were teens



Source: http://familyinequality.wordpress.com/2012/02/27/poverty-single-mothers-and-mobility/

A second and probably related caveat is that poverty rates vary significantly by ethnicity by kind of household. Lucinda Platt's research for DWP (2009a) showed that while black Caribbean families are more likely to be headed by lone parents, families in these households are in fact less at risk of being in poverty (39 per cent) than black African (46 per cent) and Pakistani (49 per cent) households in a similar situation. This is probably because of lower household incomes among the latter ethnic minority groups.

Although we do not have comprehensive data for Somali families, our interviews suggest that they probably fit the black African profile, with a higher proportion of single-parent households and very few pensioner households.

Caring in Britain, and for ethnic minorities

While there are some definitional questions regarding the nature of caring (see Chapter 2 on methodology), national surveys and the decennial censuses since 2001 have captured the general prevalence of caring. These surveys define caring as task orientated, providing an 'audit' of tasks that would need to be taken over by the state or voluntary bodies if families were not providing them.

The first national survey of carers was undertaken as part of the 1985 General Household Survey (Rowlands and Parker, 1998) and was subsequently repeated in 1990, 1995 and 2009/10. The findings of these various surveys and the censuses are reproduced in Table 3. Although there is some variability across surveys, approximately 13 per cent of adults (aged 16+) self-define as carers. This percentage has been roughly stable over time.

Table 3: Prevalence of caring by adults in Great Britain 1985–2011

	1985	1990	1995	2000	2001 census	2009/10	2011 census
Male	12	13	11	14	11	10	9
Female	15	17	14	18	14	14	12
Age 16–29	7	8	6	8			
Age 30–44	14	15	10	13			
Age 45–64	20	24	20	24	20	17	14
Age 65+	13	13	13	13	12	14	
All	14	15	13	16	13	12	11

2009/10 survey was England only.
2011 census data refers to those aged 5+ in England and Wales.
Source: General Household Survey, 2001 Census, 2011 Census

These surveys typically ask if respondents had extra responsibilities resulting from looking after someone who has long-term physical or mental ill health or disability, or problems related to old age. In the more recent studies, the respondent is asked to confirm that this help is not provided in a professional capacity and questions further differentiate care in the same household from care provided outside the household. The 2001 and 2011 censuses included the following question, with respondents indicating the hours they spent caring: 'Do you look after, or give any help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age?'

We report these findings in greater detail in Chapter 6, but evidence suggests that there are roughly half a million ethnic minority carers in the UK. Half of these are in work and 40 per cent live in London (Carers UK, 2011b). These carers suffer poorer health than white carers, are more likely to be struggling financially to make ends meet, and are more likely to be caring for a sick or disabled child, especially for an adult disabled son or daughter aged 20 to 24, reflecting long-term and enduring caring responsibilities. As with the general population, more are female, and perhaps half are between 40 and 54 (with many being part of a 'sandwich generation' caring for both children and parents).

There is a common assumption that within ethnic minority groups family care is provided by 'their own' and that caring among black and ethnic minority families is reciprocal and characterised by informal social support (Atkin and Rollings, 1992). Reynolds and Zontini (2006) identified three ways in which reciprocal relationships work in families: intergenerationally (between parents and children, grandparents and grandchildren, uncles and aunts and nephews); intragenerationally (between siblings, cousins) and transnationally (when reciprocity operates among family members across geographical boundaries).

It is important to consider the differences between ethnic minority groups as well as drawing comparisons with the general population. Victor, *et al.* (2014) investigated the prevalence of caring among adults aged 40+ in minority groups and broadly supported the pattern described above, finding the highest rates of reported informal caring in the Indian, Pakistani and Bangladeshi populations, and the lowest levels in the black African groups. This is not simply an artefact of the demographic profile as both the Pakistani and black African groups are young populations, but levels of reported caring are very much higher in the Pakistani group. These figures should be treated with some caution, however, given that there is not yet a

uniform definition of informal carers, nor is there adequate evidence of how age, class, gender or ethnicity influence responses to survey questions about care.

We further discuss the issue of informal care in the chapters below, but a key element is that such care and assistance is not provided directly for money but rather stems from the complex relationships of responsibilities and obligations that arise within families or long-term friendships and relationships. Not only are such notions more difficult to define and measure in a robust manner, but the notion of what counts as 'informal' may vary culturally, historically, across generations and by other factors such as age, class and ethnicity. For the purposes of this research, this also raises an interesting question about whether family ties and obligations should be viewed as opportunities or constraints, and whether informal caring is always best understood through the prism of 'choice'.

This suggests a final line of inquiry in our research: whether various groups may have different attitudes or preferences, specifically regarding balancing work and care. In particular, different preferences may influence people's understanding of and uptake of services. Among ethnic minorities in the UK these may or may not be based on cultural or religious influences, but they are significant in the wider literature. For example, as with other South Asian groups, there is a significant literature on Pakistani attitudes to care for older people. Evidence suggests that Pakistani families prefer to care for their parents and indeed other relatives in their home, and are less likely to choose care homes. This preference clearly affects the kind of care they end up choosing for themselves and their families.

In terms of caring, there is evidence that Black Caribbean people are *more* likely to use formal childcare, and we also speculate that they are more likely to be using caring services for their older relatives (not least given their older demographic profile). This highlights a significant question throughout this research, namely whether and how ethnic minorities access services, and their wider engagement with public bodies. Somalis appear to have somewhat worse access and are less likely to be involved in existing black and minority ethnic networks to help facilitate this access. We found substantial evidence of lower uptake of some services, partly through lack of awareness or knowledge.

Uptake of services leads naturally into a discussion of policy, as caring and employment services are obviously key levers for improving people's options in terms of balancing work and care. This again connects the choices people make, and the opportunities or constraints that shape those choices. In Chapters 4–6 we discuss our findings on childcare, caring for children with a disability and caring for older relatives, and how this framework of choice and opportunity makes sense of our findings.

4 CHILDCARE

This chapter reports our findings on childcare and work among our Carribean, Pakistani and Somali participants. We first outline wider changes in the UK economy, and policy responses to those changes, to explain how and why the greater prevalence of poverty and poor labour market outcomes influences the choices ethnic minority people make around childcare.

Understanding the various opportunities and constraints influencing people's takeup of childcare is not only valuable in itself but also provides insight into how low-income ethnic minorities balance work and care, and the sorts of considerations that inform their choices.

The welfare state and childcare

One of the unstated assumptions of the postwar welfare state settlement was that women would be caregivers and raise children, with some state support for children, education and health, while men would be breadwinners and build up pension rights to support the whole family in employment and then retirement. This high-level context is important for understanding how childcare policy developed, and why there is increasing discussion about the need to balance work and care. In the UK, the NHS was developed as a key aspect of the welfare state, but the postwar welfare state in Britain is generally characterised as more 'maternalist' than European counterparts (see Orloff, 2006).

A very brief summary of developments over the last few decades is that welfare states have reduced their support for women as mothers, and expected (or demanded) that women work (O'Connor, Orloff and Shaver, 1999; Sainsbury, 1999). At the same time (and sometimes interpreted as a related point) male wages have failed to keep up with inflation and the cost of living, and there has been very little policy focus on encouraging men to take up more caring roles (with the partial exception of Scandinavia, where

parental leave is intended to promote further caring among fathers, and where education policy attempts to rebut 'heteronormativity').

Obviously this traditional welfare state is under pressure from a variety of directions, including progressive ageing, but other social changes have also played a role. Traditional gender hierarchies and roles have been actively challenged and resulted in increased female labour market participation. For some groups, including Black Caribbean women, this has resulted in higher labour market participation for women than men, although their wages are still often lower than those of their male counterparts.

These changes have not, however, led to a full-scale reform of the welfare state. In particular, childcare in the UK is very expensive, and the labour market has not responded sufficiently in terms of flexible working or by removing the barriers women face. Nor have men generally changed their attitudes or roles in terms of caring, with women – even those in work – much more likely to do the bulk of caring, whether for children, disabled people or older people.

It is also worth emphasising that childcare is not and should not be viewed only from the perspective of parents, and in terms of their labour market participation. Research shows that good-quality childcare leads to improved cognitive and social development for children, especially after the age of 2 or 3, and so policy has promoted childcare or 'early education' for these benefits, independently of any benefits for parents in the workplace. This explains why successive governments have introduced and then extended 15 hours of free childcare for 3- to 4-year-olds (and soon for some 2-year-olds).

Childcare is not and should not be viewed only from the perspective of parents, and in terms of their labour market participation.

Nevertheless, childcare in the UK is very expensive and difficult for parents to secure. According to international comparisons, UK childcare costs are the second highest among the member countries of the Organisation for Economic Co-operation and Development (OECD), with relatively little state support compared to other countries (OECD, 2011). There are too few childcare places, especially in London, and childcare sufficiency assessments indicate that 15 London local authorities did not have enough breakfast or after-school provision, while another 16 local authorities did not have sufficient holiday childcare to meet demand.

Childcare is also significantly more expensive in London than the British average. According to Daycare Trust research (2012b), nursery care for under-2s in London was 24 per cent more expensive than the British average, and 17 per cent more expensive in inner London, while out-of-school childcare in London was 4 per cent more expensive than the British average. Even a relatively positive development may have mixed results in London, given existing supply and costs: Daycare Trust research suggests that the extension of 15 hours' free early education to the 40 per cent most deprived 2-year-olds by 2014 may result in shortages of nursery places in some parts of London. This is because many parts of London have high levels of deprivation, so qualifying 2-year-olds may fill as much as 70 per cent of the allocation.

Ethnic minorities and childcare

These background policy developments and the data on childcare costs in London are particularly relevant for ethnic minorities, given that they are 46 per cent of the capital's population (compared to 14 per cent for England and Wales overall). Around half of black people in the UK live in London, including two-thirds of Somalis, and though fewer Pakistanis live in London

compared to other ethnic minority groups, they are still more likely to live in London than white British people are.

The high costs and low supply of childcare – issues that are particularly pressing in London – are of course an even greater challenge for those living in poverty. We have already outlined the employment and poverty background for Caribbean, Pakistani and Somali people, and it is worth connecting this data to the provision and experience of childcare. For many parents getting work is not easy to balance with childcare, whether in terms of cost (wages do not cover childcare costs) or time (jobs are not suitable for childcare hours). Ethnic minority groups have higher rates of unemployment, lower wages, larger household sizes and high rates of in-work poverty. These worse labour market outcomes and higher rates of poverty among ethnic minority groups mean that 58 per cent of Pakistani and Bangladeshi children and 47 per cent of black British children currently live in poverty, but they also result in their parents facing poor choices in terms of balancing work and childcare. For example, the median wage for a Pakistani man in the UK is only £7.74 an hour, meaning that the average nursery place rate of £5.07 an hour in London is relatively unaffordable. Given the income and poverty data we have already outlined, it is hardly surprising that ethnic minorities struggle to meet these childcare costs, especially if there are upfront costs coming out of initial monthly wages for those entering or returning to work.

Labour market segmentation is also likely to mean that ethnic minorities struggle to access appropriate or affordable childcare. There are significant gaps in supply for older children and for parents who work atypical hours or need sessional childcare, and these are most acute in London, where a larger proportion of ethnic minorities live. There are also significant difficulties in accessing childcare before 8am or after 6pm, which again is likely to affect ethnic minorities disproportionately, given their greater prevalence of unsociable working hours.

Childcare provision is typically divided into 'formal' and 'informal' care. Ethnic minority groups have very different experiences of childcare. Black Caribbean people are most likely to use formal care, whether 'group' (30 per cent – nurseries, crèches, children's centres) or 'non-group' care (15 per cent – childminders, nannies, au pairs). Conversely, they are much less likely to use informal parental or partner care, with only 29 per cent of families using this kind of care. Pakistanis and Bangladeshis have more or less opposite care use for their children. Over 70 per cent of both groups use parents or partners for childcare, with almost none (0.3 per cent) using formal non-group care, and only 7 per cent using formal group care.

Black African groups have generally closer childcare use to white groups, or between black Caribbean and Pakistani/Bangladeshi childcare use (see Table 4). The black African ethnic group includes people from a very wide range of backgrounds, and based on our findings Somali childcare use would appear more like that of Pakistanis and Bangladeshis than of other parts of the black African population (compare Daycare Trust, 2008).

Table 4: Childcare use by ethnicity at 3 years (percentage)

Main childcare type	Ethnic group						
	White	Indian	Pakistani	Bangladeshi	Black Caribbean	Black African	Other
Formal group care	17.9	18.4	7.2	7.3	29.8	21.6	22.9
Formal non-group care	9.5	3.9	0.3	0.3	15.3	10.4	7.4
Informal parent/ partner care	41.5	40.5	70.5	75.6	29.3	46.4	45.3
Informal grandparent care	22.6	27.4	14.7	11.1	16.7	6.1	16.9
Informal other care	8.5	9.9	7.4	5.8	9.0	15.6	7.5
N	*11700*	*359*	*669*	*254*	*156*	*256*	*639*

Note: All rates are weighted to account for survey design. Sample sizes are unweighted. Formal group care includes nurseries, crèches and child/family centres. Formal non-group care includes childminders and nannies. Informal parent/partner care is a residential parent. Informal other care includes playgroups and care from neighbours and other relatives.

In interpreting these findings it is also worth remembering that ethnic groups vary in terms of their family structures, with higher rates of lone parents in black Caribbean households and lower rates among Pakistanis. This means they face different choices in terms of balancing work and care, perhaps partly explaining the very high labour participation rates of black Caribbean women and the very low rates for Pakistani and Bangladeshi women. Yet high rates of labour market participation do not mean that single Caribbean women easily balance care and work. In London 92 per cent of single-parent households were headed by women and the median hourly wage for female part-time workers is just £9.25, leaving a three-day-a-week worker with only £87.78 per week (less than £5000 annually) after paying for the average cost of a nursery place at £5.07 per hour (Daycare Trust, 2012b).

Black and minority ethnic families also tend to be larger than white British families. For example, 43 per cent of Bangladeshi, 33 per cent of Pakistani and 7 per cent of Caribbean families have four or more children. This compares with just 4 per cent of white British families (FIRST, 2004). However, among our sample, no Caribbean and only one Pakistani family had more than four children; this may be explained partly by decreasing fertility since the above research was conducted, partly by higher childcare costs in London and partly because some mothers we interviewed may yet have more children.

Experience of formal childcare

As indicated above, national data suggests that while Caribbean people are more likely to use formal childcare, Pakistanis are significantly less likely, with black Africans somewhere in between and fairly close to the white British population. While our findings confirmed the Caribbean statistics, we found somewhat higher use of formal care services among the Pakistanis we interviewed, and very little use among the Somalis.

In addition to any effects from our small sample size, we suspect that our findings can be explained because the national dataset does not separate Bangladeshis and Pakistanis or distinguish among the diverse black African group. Our interviews suggest that Bangladeshis have much lower rates of

uptake of formal childcare than Pakistanis (see also Daycare Trust, 2008, in which Bangladeshis had the lowest rate), while Somalis are perhaps only 1 in 5 of the black African population, and appear to have somewhat different experiences of formal childcare than other black Africans.

Formal childcare can be split into group care (nurseries, crèches and child/family centres) and non-group care (childminders, nannies and au pairs). We found no use of nannies and au pairs but significant use of childminders among our Caribbean interviewees and somewhat lower use among our Pakistani interviewees. Among the various barriers to the uptake of formal childcare are affordability, discrimination and cultural needs for different parents.

For all our interviewees, affordability was a major concern. This was clearest among the Caribbean participants, who were also the group most likely to use formal childcare, and thus obviously most aware of the costs. Almost none of our participants used full-time childcare, with those using some formal childcare typically supplementing this with informal care on cost grounds. Even among those who did not or would not consider using formal childcare there was widespread awareness of its cost, including among Somali women who spoke almost no English. While we have not made a clear recommendation on how best to reduce childcare costs generally in the UK (as there is a variety of proposals for doing so but none of these were directly discussed with participants), this would undoubtedly increase the uptake of childcare for ethnic minorities and indeed everyone in Britain.

"What I would like to say is government should make childcare affordable ... Why do we have to pay extra if we want to send our kids to the nursery full time? ... We are paying tax ... And if nursery was free for full-time use then more parents can take up jobs and contribute towards the economy as well. And also government should design the jobs which are suitable to mums ..."

Caribbean woman

Interviewer: "Would the cost of childcare prevent you from having more kids?"
"Yes it will ... We want to have one more kid though ... But yes it will stop us because we want to make sure we provide the best care for our kids ..."

Caribbean woman

Interviewer: "Do you access formal childcare in your area such as council educational services that look after your children?"
"No ... I don't actually use it."
Interviewer: "May I know why?"
"I am not working now so I can look after them and my wife has always been a housewife so there has never been a need ... Plus it's expensive ... I can't afford it."

Somali man

In general we found relatively little evidence of direct racial discrimination. This is in part because of the low uptake of formal childcare, particularly among Pakistani and Somali parents. However, we did hear some

interviewees express a concern about the fairness of their treatment, a concern that typically focused on the possibility that an individual member of staff might be discriminatory or prejudiced, rather than that the caring institution or environment as a whole was discriminatory.

Our findings may be compared with previous Daycare Trust (2008) research that black and minority ethnic children and parents and children with special educational needs regularly suffer abuse by staff and other parents. It also resonates with an older study that found that white families had the highest quality of childcare services, while Asian families had the lowest (FIRST, 2004).

"When she first started there was a staff person who had a problem with her ... sometimes in life you get these people who assume that because you're black and the daughter of a single mother and because your father's not around you must be a problem child or have a bad attitude ... I brought my daughter up with manners and to respect people but I told her in life you will meet many people who will judge you like this ... you have to be strong and remember what your mama told you! Now thankfully she doesn't have a problem because that staff member left and they got to know her now and realise she's a well brought up girl"

Caribbean woman

For those using childminders, this sometimes appears to be a way of ensuring that carers match a parent's religious or cultural preferences, particularly in the Pakistani community. And although we found almost no use of childminders among Somalis, some did say that they would use them if Somali childminders were available. Indeed, in our Somali focus group of eight mothers, nearly everyone agreed that they would be willing to train and act as a childminder themselves – confirming previous findings that mothers often express interest in and enthusiasm for setting up childminding businesses of their own (FIRST, 2004; see also **Recommendation 7** in Chapter 7).

One barrier to mothers establishing their own childminding business is regulation, and in particular training and child protection requirements. While some Somali interviewees did query the degree of regulation for childminders, some of their concerns addressed English language provision. Other interviewees rather expressed satisfaction with the level of oversight of childminders and childcare generally.

"What I liked is that this lady was checked out by the council and she had all these certificates ... she had to fill in forms about [my child] like how she was anything different about [my child] so it made me realise that this was a professional type person ..."

Caribbean woman

In terms of nurseries and children's centres, these had relatively low uptake among the Pakistani and Somali group, with only one Somali and a few Pakistani interviewees using these services. Given evidence that formal group childcare has significant cognitive and social effects, this may disadvantage their children, although our interviews suggest that parents are not fully aware of these benefits. As anticipated, Caribbean parents were

more likely to use formal childcare including nurseries, and in general they were happy with the provision (with the exception of cost).

"It's a nursery for Muslim children ... it's run by a white lady who converted to Islam ... she's very good and my child is very happy there ... we have a mix of Muslim people there like Somali and Pakistani and Arab and Iranian ... it's all very nice! ... My sister's son also goes to this same nursery ... she recommended it to me ... also my husband ... prefers all our children to have an Islamic upbringing ..."

Somali mother

Finally, one area where Pakistani respondents did appear to use formal childcare related to school provision. Many parents spoke of using after-school clubs, or additional recreational, music or other activities offered by local schools. This suggests that the 'early education' framing of childcare may prove particularly effective, as parents of all ethnic backgrounds appear more willing to take up provision when it is framed in terms of education, and where it is offered for free or limited cost by the local school.

Experiences of informal childcare

A significant proportion of parents in the UK use 'informal' childcare, particularly family members. It is sometimes assumed that ethnic minority groups are more likely to access informal childcare. While we did in fact find significant support from grandparents and other family members, particularly among Pakistani and Somali interviewees, these figures may not be higher than white British people, among whom many grandparents (particularly maternal grandmothers) provide care support.[11] Another important factor in the relative uptake of informal care is the fact that – due to the more recent presence of some groups – children often do not have all four grandparents living in the UK.

Although we did not interview white British people, we suspect that among some of those ethnic minorities who use informal childcare, a small but significant minority use it in a more intense way. That is, even if the overall prevalence of informal care is similar in both communities, there may be more situations where ethnic minorities turn to their wider family and community for childcare support, and they are less likely to use formal options in other situations.

People generally view their family relationships as deeply valuable. Fulfilling familial obligations is important in itself and for the sense of personal identity. More simply, people often want to care for their own children based on the love they feel for them. To call this 'informal care' may seem a peculiarly policy-driven or academic way of talking about the fundamentally loving relationship between parent and child. Indeed, many of our interviewees consistently used the term 'love' to describe their relationship.

"I learnt to only go to friends' houses when he is fine, so I have had to make some changes, but it has been worth it so I don't mind anymore because like I said before it's my duty – I love my son and it makes me happy to know that I am helping him"

Pakistani woman, 52

The above discussion suggests that our framework of opportunities or constraints that shape choices may not be wholly apt. That is, people who value their family obligations would not view these responsibilities as a 'constraint', but they may also not believe that they can 'choose' to fulfil those obligations. And even if we describe their actions as choosing within a set of constraints, that may not accurately describe how people think about their decisions, or the motivations that drive them.

"As the father it is my duty and if I am not caring then I am not a good father because that is what a father is supposed to do"

Somali man, 48

Interviewer: "What kind of help is available to you in terms of childcare?"
"Normally my mother-in-law helps out. She helps in the household work too. If I have any appointments or parents meeting I leave the kids with her. I also have my sister-in-law next door and mostly kids are at her house and sometimes her kids come to our place. It's helpful because then I don't have to rely on an outsider for childcare and same thing for my sister-in-law ... Either I or my mother-in-law is always there ... It's almost like a daily kind of thing. Kids go to next door whenever they feel like ... And also my sister-in-law's kids come to my place whenever they want."
Interviewer: "If you had to go somewhere (say once a week for three hours or so) without the children who would you call to look after your children?"
"Either my sister-in-law or my mother-in-law is always there so it won't be a problem. My mother-in-law's health is getting better so she can look after them ... They are not hard to manage ..."

Pakistani woman

The above quotation shows the strength of certain kinds of social networks in many ethnic minority communities in the UK. These networks often extend beyond immediate family members.

"I look after Mrs X's children and have done so since they are now going to university. Aah aah, you think caring is word only, it's love and cherish ... you know. [Gestures with hands] It's real love. When xxx was ill, Mrs X would say ... 'Please keep an eye on them' ... I would do that and be there ... I will not let anyone care and the child knew I was there"

Caribbean woman, 79

These networks may be particularly valuable for new migrants who otherwise may not understand or be familiar with local childcare services, and who are less likely to know other local mothers (or fathers). At the same time, there can be limits to local networks, for example where those networks do not extend into other parts of society and thus restrict members' knowledge or

awareness of service provision. While it may, of course, be rational and safe to cultivate and participate in social networks focused on one's ethnic group, those networks are often limited, particularly in the area of employment (see McCabe, *et al.*, 2013).

Barriers to childcare: knowledge or awareness and cultural preferences

This section addresses two possible barriers to childcare that are likely to be somewhat different for ethnic minority parents in the UK. The first is knowledge or awareness of services. For example, a DWP report found that Bangladeshi and Pakistani mothers had low levels of awareness about local childcare services because they had not looked into them – simply because they did not know they existed. Other research has also found that these groups have low awareness about childcare support (Bunglawala, 2004; 2008; APPG, 2013; Daycare Trust, 2008).

We did find some evidence of this among our interviewees. Even among Caribbean families who had relatively high knowledge and awareness of formal childcare services, they appeared to use word of mouth and local networks to seek out knowledge of childcare services. This may not be entirely dissimilar from white British parents, of course, and in general Caribbean parents were aware of local childcare provision. Among Pakistani and Somali parents, however, knowledge or awareness was quite low. This may partly relate to the following point, namely that parents seek out culturally appropriate care and do not believe this sort of tailored care is available. However, we found very low levels of awareness about the availability of local childcare, its cost and government policy. Among our Somali interviewees awareness was particularly low, with only one using formal childcare.

We found very low levels of awareness about the availability of local childcare, its cost and government policy.

Knowledge of existing provision is one important way to measure awareness. Another measure we asked about was existing policy, and in particular the availability of free childcare. In 2010 and 2011 the government expanded the number of places for the free early education entitlement for 3- and 4-year-olds of 15 hours per week to cover 40 per cent of 2-year-olds (Daycare Trust, 2012b). This may support black and minority ethnic families, although Daycare Trust evidence (2008) suggests that some groups are less aware of government policies such as Sure Start, due in part to their finding out about services through word of mouth (and their networks not including people who know more about services either). Others see such services as irrelevant to them. Further barriers for black and minority ethnic people include access to information, costs, location of services, language and cultural considerations (Daycare Trust, 2008).

Confirming these findings, we found limited knowledge of the policy of free early education entitlement for 3- and 4-year-olds. Some of this lack of knowledge may be explained by the fact that many respondents had children older than 3–4 years. Here again there was a significant difference in awareness among the various ethnic minority groups we interviewed, with the Somali group least likely to know about provision (none of the eight Somali focus group participants knew about it). This suggests that the government must do more to improve understanding of people's entitlements, especially access to free childcare.

The need for local services to respond to cultural, religious or language needs and preferences is by now a familiar one in the UK but remains a barrier to uptake of formal services. In terms of childcare, Pakistani and

Somali respondents particularly noted that they would be more likely to take up formal childcare if the service was culturally appropriate.

Interviewer: "If you were given a choice would you use culturally appropriate service or mainstream?"
"I will prefer somebody from my culture. Somebody who speaks Urdu so my mum can interact with her. My mum speaks very little English. She's the one who will mainly be dealing with the person and also I personally want somebody from my culture ... Because he/she knows about principles of Islam ... For example only to give Halal food and how to maintain cleanliness."

Pakistani woman

As this quotation indicates, it is not always easy to separate culture, religion and language. Among Somali participants, some seemed to suggest that language and religion were most important. Some mothers expressed a concern that the environment was 'safe' for their children: when asked what they meant they described the notion of a childcare setting where respect and other values were properly taught to and taken up by children. This was associated with Islamic values. Of course, all parents expect their children to follow values that they themselves defend (an expectation that is affirmed in Article 26 of the Universal Declaration of Human Rights.[12]

Among Pakistanis and particularly Somalis we found some concern about racism or Islamophobia. Previous research on Somali groups suggests significant experience of Islamophobia in public, including on buses and in public spaces such as parks. This will obviously result in their being less comfortable with 'local' cultures, and for some Somalis it appeared unlikely that they would take up mainstream services as these too were judged to be 'inappropriate'.

Caribbean respondents, by contrast, explicitly knew about and took up mainstream services. In fact, some respondents strongly felt that parents should use such services for the benefit of their children, indicating a preference for this kind of care and an awareness of the cognitive and social benefits of formal childcare. On the other hand, some Caribbean parents noted different child rearing practices in their community, and also expressed concern about racism and discrimination. This latter point was less commonly heard, and often confined to the past or to individual care workers rather than an entire institution. On the other hand, some Caribbean respondents did suggest some cultural differences that they felt were relevant in taking up childcare services.

Interviewer: "In your community what do you think people think about childcare?"
"They expect you to give best childcare possible ... They expect you to fulfil their needs ... Give them love and make them into a good person. I think it's the same in any other communities too. In my culture the women in the house get together to collectively look after the children: the men are not as important like in some other communities like my Indian friend's husband ... My mother is still an important part of our lives even though she moved after a while because our flat was too cramped. It's the same in

many Caribbean families ... the women have to be strong; it's who we are."

Caribbean woman

This quotation also raises another issue: while some respondents initially expressed a preference for 'culturally appropriate' services, it soon became clear that they would actually prefer a family member to look after their children. This was particularly common among Pakistanis, among whom a familial connection appeared more important than cultural knowledge or competence. Interestingly, for the Somali community, while many did use their family members to provide 'informal' care, the concern was more around cultural or religious competence, and some even said they would be happy with a non-Somali who understood and respected their culture.

Interviewer: "What would be your preference if you have to choose between a family member and somebody from your culture?"
"I will definitely want a family member ... Before my mother-in-law used to look after the kids and it was so helpful ... Children can learn family values and an outsider even though from my culture can't teach that."

Pakistani woman

One further hypothesis for the Pakistani community is that 'biraderi' or 'clan' may be more relevant than culture generally. Biraderi is a kinship tie in Pakistani communities, especially among Kashmiris, and can be very important for people in terms of their personal and moral obligations to one another. Towards the end of our research, we asked some respondents about biraderi more explicitly.

Interviewer: "How important is it for you to have a person from same biraderi for you and why?"
"I am not too much into it but my other family members are. My mother-in-law and husband would never allow a person from another biraderi providing childcare because children won't learn the right values and cultural aspects of the life from that person ... But for me it doesn't matter because I can teach them myself afterwards."

Pakistani woman

Finally, it is worth highlighting that many respondents understood that they were more likely to access 'culturally appropriate' care via a childminder than in a nursery. The Pakistani families who used childminders explicitly mentioned this, and the Somali focus group also noted the need for more trained childminders from the Somali community. This strikes us as a win-win situation, as more Pakistani and Somali trained childminders could increase uptake of childcare while reducing unemployment and inactivity rates among groups with the worst labour market outcomes. While not all mothers would seek or should be encouraged to become childminders, nearly all participants in the Somali focus group expressed willingness to look after other Somali children as a way of managing childcare and work.

One obvious concern here is the lack of adequate ESOL provision. Language skills are a major reason for Somali women's poor access to the labour market, and while many of our interviewees expressed a desire to learn English and indeed get more education and training generally, their childcare responsibilities made this very difficult. While there is a real concern if children do not learn adequate English, both in terms of their ability to interact with others in the UK and in terms of their opportunities later in life, there may be a case for registering some Somali childminders whose English is not quite fluent: this would not only provide the Somali childminder with work but also enable the mother of the child to seek out additional training and education. Since most of these children are currently looked after by their mothers, their caring situation in terms of language opportunities and access to English is unlikely to be any different.

Working and caring from a gender perspective

As we have already outlined, ethnic minority groups generally, and the three groups we interviewed specifically, experience significant labour market disadvantage. All groups have lower wages and higher unemployment, with less access to secure jobs and job-related benefits. This is true for men and women, and where the man is the sole earner, these experiences obviously have an impact on income levels and the caring choices for women in those households. In this section we consider further how Caribbean, Pakistani and Somali women's experience in the labour market affects their attitudes to and uptake of caring.

Although black Caribbean women have very high labour market participation rates, Pakistani and Somali women have very low rates. Both in the literature and among our participants, gender was a particularly relevant factor in thinking about 'balancing' work and care. For most Pakistani and Somali men, it appears that they do not have to 'balance' work and care personally as the assumption is that their wife or partner will meet most caring responsibilities. To put it more bluntly, the balance is: men work and women care. There is some evidence that this is changing, at least in the Pakistani community, while Caribbean women spoke much more about 'equality' in terms of caring responsibilities.

While many of the women we interviewed clearly had a strong love for their children and intended to have children at a young age, almost all also sought to work. We found very little evidence that women did not want to work at all, although some expressed a reluctance to do so when their children were very young. Many participants, however, expressed a clear preference to work part time, but highlighted the difficulty in finding suitable opportunities. Again chiming with previous research (see Wood, *et al*., 2009; APPG, 2013), flexibility at work was a key factor cited by women seeking to juggle work and family. Some respondents appeared only to be able or willing to work part time, and would not work unless the hours fitted around childcare.

It is also significant that previous research suggests that women end up taking up jobs for which they are over-qualified, given the lack of opportunities for high-skilled or good part-time work. Conversely, many women who work part-time would like to increase their hours, in part to improve the quality of their jobs. However, the pressures of caring for children often means these preferences for better full time work are unrealised.

"I would like to earn good money and have the chance to become better in my job and to become successful. I would like to work full time in a bank. If was not able to work full time then I would work in a school, perhaps in the office or in the classroom. I would like to do training to help with this. It is very difficult for me to do this and I do not think that I will be able to until my children are older"

Somali woman

A recent report (APPG, 2013) on female labour market participation found significant evidence of discrimination against ethnic minority women, and this too was mentioned by a number of our participants. The very high unemployment rates among Pakistani women (higher than for any other group) suggest some element of discrimination, given that most Pakistani women are economically inactive and so those seeking work are more highly qualified. Somali women were also likely to mention Islam and their wearing of a headscarf as being a barrier among employers. Black Caribbean women also expressed a belief that discrimination remains a key factor in the labour market, and national evidence suggests that over 60 per cent of black Caribbean people feel that discrimination still affects their life chances (Heath and Khan, 2012).

"I do not work and feel that I cannot because of my headscarf and my religion I pray and they won't allow me to do that ..."

Somali woman

As discussed above, English language skills were clearly related to work among our respondents, again confirming earlier research (see, for example, Aston, *et al*., 2007). Women were very aware of how English use affects their ability to find work, and indeed many sought to improve it, but found it difficult to do so, given the lack of ESOL or similar provision and the need to balance classes with childcare.

In thinking about how people balance work and care, it is important to understand their attitudes to and motivations for having children, and their care expectations (personally and within the family) for those children. Among Pakistani and Somali women, most usually expressed their desire to have two or more children at a younger age than the current British average. Especially among Pakistani interviewees, however, there appeared to be a significant change compared to the older generation, with only a few of our Pakistani interviewees having more than three children, suggesting any cultural preference for larger families is weakening among UK-born women. As DWP research has also found, these Pakistani women expected to have more time with each child and were more aware of the benefits of childcare, even if they did not take it up (Aston, *et al*., 2007).

Here we found significant differences (across ethnic groups and by gender) in terms of when mothers might decide to return to the labour market following the birth of a child. Current policy appears to assume that mothers will look after children for anything from 39 weeks (the period of statutory maternity pay) to 2 years (when free childcare support is first provided to low-income mothers). Employers clearly expect women to return to work within a year, although many women wait until children enter school at the age of 5 before returning to the labour market.

However, among a number of our interviewees, parents appeared to believe that children required parental – or rather specifically maternal – support to a later age. Quite a few of our Pakistani and Somali respondents suggested that they could only return to work once their children were as old as 12 or 14 years. Yet people who are out of the labour market for even 1 or 2 years experience serious difficulties in accessing work, and our interviewees did not always appear to understand the consequences of more than a decade of labour inactivity.

Interviewer: "Is there any reason why you are not using formal childcare services?"
"It's not quite useful to me and I prefer to give my time to them ... I don't want to miss out and this is the age where they need the guidance and proper care because they can be badly influenced by others if not given attention."

Pakistani woman

"People in my community are grateful for children they enjoy family life and look after the children ...The women are in charge of looking after them ... children are seen as a gift from God and to be nurtured ... a woman's role in this is vital and essential to the healthiness of society ... it's an honoured role and it's also very hard! A man is seen not to have the patience or emotional ability to care for children ... they can to some level help but not completely as a woman is able to ..."

Somali woman

Some of the women we have spoken to did work when their children were younger, although this was often a case of financial necessity. Among Caribbean women, almost all were in current employment, and almost all had needed to balance work and care at some point. However, this balancing could be very stressful, and finding appropriate (and affordable) childcare provision could take some time.

Another factor that emerged was health. There is much higher self-reported ill health among Pakistani people nationally, with higher rates of disability after the age of 40 too. Among our interviewees, health was mentioned as a barrier to work, and a significant minority also mentioned depression or mental health issues. Some of this arose from their particular circumstances, especially for those who found there was not enough money to make ends meet. For the Pakistani and Somali women who had separated from their partners, this often appeared to result in greater isolation as they may not have extensive social networks independent of their husband's. Among Caribbean respondents too, the strain of trying to balance work and care while on low incomes clearly proved difficult.

Although we do not wish to suggest that these experiences are always negative, among a number of our Somali respondents we heard that the increasing numbers of single-parent roles as a result of marital breakdown pose challenges in the labour market and more generally. Many Somalis discussed the question of male and female roles, and quite a few felt that Somali men were not fully contributing as earners or carers. While this should be placed in a context where many Somali men arrived as asylum

seekers and initially could not work in the UK, and where relatively poor qualifications and discrimination further impede their labour market outcomes, disappointment with Somali men and concern about Somali young men (as with other girls, Somali girls now significantly outperform Somali boys) was a surprisingly common theme. Partly as a result of having less support from their husbands than they expected, Somali interviewees expressed a concern about isolation among women that sometimes leads to physical and mental health problems.

A final relevant finding returns to the question of gender roles and expectations in terms of work and care. Although we did not directly ask interviewees about their expectations of mothers and fathers, or men and women, in terms of childcare, the issue emerged in almost every interview. The Pakistani and Somali families we interviewed were generally quite traditional in terms of childcare, with the mother doing most if not all of the caring, and the father relatively uninvolved in what is usually understood as childcare. We suspect this would also be true for many white British families, although of course the nature of expectations, beliefs and values would vary from family to family as it did in our research.

One point this raises is the continued labour market segmentation of men and women in the UK economy (and indeed in most economies). Previous research has found that ethnic minority women may have stereotypical 'female' career aspirations and prefer to work in the public or voluntary sector (CLG, 2009) We also found some evidence of this, with female respondents more likely to seek employment as childminders, although quite a few of our respondents were clearly aware that traditional family roles made it more difficult for women to pursue more diverse and potentially more financially rewarding options in the labour market.

"But if you think about older people, their views are completely different to mine ... They think it is male-dominated culture and a woman has certain limits. Men are free to do whatever they want but women are expected to be more being there to look after the family members and children ... A man is there to provide financial support to the family. A man is seen as a weak person if he is helping out with childcare"

Pakistani woman

Conclusions and implications

The evidence among our research participants is clearly somewhat mixed. However, one key theme is that low-wage jobs and the high cost of childcare are difficult to reconcile. In fact, although we have not talked about it at great length the issue of affordability is perhaps the single biggest barrier for accessing childcare. While it is fair to say that some interviewees had not really considered formal childcare, even they were aware that childcare was expensive.

Explicit and extensive discussion of the cost of childcare was most common among our Caribbean interviewees. While nearly all of the Caribbean respondents had used some form of formal childcare, in many cases they had reduced or stopped it as it became unaffordable, particularly if or when their employment or personal circumstances changed. Almost all respondents used informal care in some way or another, for example to fill

in gaps where formal services were too expensive, or where they needed someone to look after their children less frequently or on an emergency basis. In the Pakistani and Somali households we interviewed this informal care was usually provided by close family members.

Perhaps as important as cost was the relative level of awareness of childcare provision and policy. We anticipated that Pakistani and Somali parents would be less aware of such provision but were surprised how few knew about free childcare provision, clearly indicating a need for public bodies to provide more and better information on this important policy.

One reason parents did not take up childcare was the perception that such childcare was not appropriate or 'safe' for their children. Providers could probably do more to ensure that childcare responds to these concerns, whether by hiring more diverse staff or ensuring more 'culturally competent' care. And even if parents would not be willing to use formal childcare full time, highlighting the benefits of childcare and early education could at least improve the uptake of formal childcare to one or two days a week, or to the level of free provision.

Our interviewees clearly often preferred to care for their own children and received great satisfaction in doing so. For some parents this will mean childcare – formal or informal – will always be a second best choice. This is obviously also true for many white British people in the UK, although Pakistani and Somali parents are likely to expect direct parental involvement as the prime carer until children are older.

Lowering the cost, spreading information and improving the kind of childcare on offer will only do so much to change uptake of childcare and improve outcomes for parents and children. As we emphasise throughout this report, there remain significant barriers in the labour market, particularly in terms of discrimination, low wages and flexible work, that need addressing for their own sake and so that parents can better balance work and care. This will not mean that parents of all backgrounds will equally choose to use formal childcare, but it will enhance people's opportunities to make that choice.

5 CARING FOR CHILDREN WITH A DISABILITY

In this chapter we highlight our findings on families with disabled children. Our sample size for this discussion is small (only 13 families in total), and so we are somewhat more tentative with our findings, not least given that there are some 770,000 disabled children under the age of 16 in the UK, or 5 per cent of all under-16s (Papworth Trust, 2012).

We did, however, test our interim findings with key experts and in focus groups, further informing the analysis below. We first outline the general situation on disability and ethnicity with a focus on the limited data on families with a disabled child.

Balancing work and caring for disabled children

Our research principally interviewed carers and not disabled people themselves, so we must be careful not to assume that we have captured the experience of disability in ethnic minority communities. Furthermore, we focused primarily on carers of disabled children, as these families are somewhat easier to access, allowed greater comparison with those caring for children generally, and represent the situation for around 40 per cent of all carers (Carers UK, 2009).

Perhaps most significantly, those who care for disabled children have longer-term challenges in accessing the labour market than those who look after older disabled relatives. Parents with disabled children are often out of the labour market for many years, and if and when they return to work may be unable to work full time, further limiting their job options. Finally, caring for disabled children often involves significant costs, meaning that while parents of disabled children find it more difficult to work, they have a greater need to do so to avoid living in poverty.

Research has explained and attempted to quantify why and how families with disabled children are at greater risk of living in poverty. It is notable that the poverty rate among black and minority ethnic families with disabled children is 44 per cent compared to 17 per cent for households generally. With the poverty rate for disabled people around double that for non-disabled adults and higher than a decade ago, there are at least two specific challenges for families with disabled children: first, the considerable childcare costs that contribute to it costing three times more to raise a disabled child; and second, missing out on vital income by not taking up benefits, which research has found to be particularly prominent among black and minority ethnic families (Contact a Family, 2011).

As we have already indicated, very few of the people we interviewed who cared for their disabled children were in work. This lower labour market participation obviously contributed to higher risks of poverty, a point that resonates with national evidence. Notably, Lucinda Platt's research for DWP (2009a) found that the risks of poverty associated with living with a disabled family member were higher for Pakistani (57 per cent) and Bangladeshi (66 per cent) children than they were for black Caribbean (42 per cent) and black African (44 per cent) children, and for all these groups the risks were higher than for white children (28 per cent).

In addition, the chances of living in a household with a disabled member were much higher for Pakistani (34 per cent) and Bangladeshi (37 per cent) children than they were for black Caribbean (16 per cent) and black African (14 per cent) children. Perhaps most significantly, living in a disabled household contributed much more to the poverty of Pakistani and Bangladeshi children than it did to the poverty of other minority groups. This is in a context where 1 in 4 families with disabled children are going without heating and 1 in 7 without food.

Given these financial concerns, it is perhaps surprising that only a few of the parents we interviewed who cared for their disabled children worked. Conversely, this lack of labour market participation may be expected, given that most of our interviewees were at or near the poverty line.

"I can't go to work ... As you must be aware finding a job is hard and I can only work certain hours as I have to be looking after him. And I don't have any other support ... So I have to use every single penny very wisely. I would love work if he was capable enough to look after himself but I can't"

Pakistani woman

In those two-parent households we interviewed, one earner – invariably the man – always worked significant hours. In general, this meant that men did relatively little caring compared to women. One Caribbean male interviewee did express satisfaction with his caring situation, but he recognised that his situation was quite unusual and based on his employer offering flexible working. It is also notable that in this case the participant was caring for his adult partner, and not a disabled child. While the participant had worked full-time hours and built up a reputation for many years, this is more difficult for parents with young disabled children who typically have less experience given their younger age and the caring needs of their children.

"Because I live with my partner I am available to give her 24-hour-a-day care, which is very critical because of her ME. I am only able to provide this type of support because my boss has been sympathetic to her situation and allowed me to work from home... As I've said too, I am extremely lucky in some ways because this has a positive effect in employment terms as I have been working from home for the last 5 years"

Caribbean man, 50

Among one or two Caribbean interviewees, the mother was both a carer and worked, and this clearly involved balancing a wide range of responsibilities.

"Because as a single mother I'm doing the normal motherly things like dropping the children to school, cooking for them, helping with their homework, washing and ironing their clothes. As well as all of this I'm giving my son that extra care and attention he needs because of his learning"

Caribbean woman, 44

In the one case where a Pakistani mother was working (part time) she was only able to do so because of the full-time support of her mother-in-law. She reflected on the changes after her son was diagnosed with Down syndrome.

"It has not affected my personal life that much as much as it has affected my mother-in-law. She is the one mainly with him ... she can't socialise as much as she used to do before. With my daughter it's alright because if she takes her to her friend's house ... she would start playing with other kids and she won't be a much of trouble for my mother-in-law ... but even thinking of doing same with my son will be madness ... Also my mother in law loves both my children very much but because he's the only boy and he's not seen as 'normal' it's a cause of sadness for my mother-in-law ... she doesn't mention this but I know it"

Pakistani woman

These findings are in fact typical for all people in the UK who care for disabled children. Research suggests that only 16 per cent of mothers with disabled children work, compared to 61 per cent of mothers with non-disabled children (Langerman and Worall, 2005). While our numbers were even lower than this figure, this may be explained as much by the greater poverty among our research participants as by their ethnic background. A final theme in previous research that very much resonated among our research participants was their greater degree of isolation, with 54 per cent of respondents to a previous survey indicating that not having the time or money to do things that other families do made them feel isolated.

Working, caring and the value of loving relationships

The difficulties of balancing care and work and avoiding poverty were a key theme among our interviewees, but the main reason was less about the quality of work or care and more about the value of personally caring for one's own disabled child. In general, the overriding concern was that their children had adequate love and support. As we address in the following section, this did not typically mean that parents felt that carer or other support services were inadequate or inappropriate, but it did mean that parents of disabled children often felt they needed to spend more time caring personally for their children.

This preference to care personally for their own children has already been raised above in the context of childcare, especially for our Somali and Pakistani respondents. For parents of disabled children, this preference was stronger still, but is one that appears to cut across all ethnic groups and is arguably not wholly explained by cultural or religious beliefs. For example, our Caribbean respondents also affirmed that they were particularly concerned to be personally involved in the care of their disabled children.

Because parents frequently preferred to care for their own children, often full time, they did have a slight preference for care in the home. This, again, is not so different from national evidence for all ethnic groups. As we explain further in the next section, in general, parents sought care for their disabled children that was appropriate to their needs rather than always preferring a carer of the same ethnic or religious background. And while many parents did prefer care in their homes, they did not feel that carers were unaware of their cultural needs or expectations.

Interviewer: "Would you be happy to receive support in your home?"
"Yes I will be because then he is at the house and all the dietary needs and cleanliness that is religious requirements are met and my mother-in-law will be relieved too. She won't have any objection because I can be there at certain time."

Pakistani woman

Interviewer: "Would you be happy to receive support in your home?"
"Yes definitely. It would really be great if that can be possible. So many problems will be solved ..."
Interviewer: "And would it matter if any support was delivered by a member of your ethnic group?"
"I don't mind it at all."

Pakistani mother

In fact, for some parents the concern for adequate care meant that they were willing to go to whatever location provided the best care for their disabled children, although if transport links to a particular location were difficult, this was obviously a barrier. In general, the key point is that while parents often preferred to care for their children for many hours, if not full time, this did not exclude them also seeking out other support. If this was available in their home, so much the better, but the overriding consideration

was to provide good care for their children, which many parents interpreted as combining near full-time care from a parent with all available support from services.

In sum, for most people caring for disabled children, the barriers to entering or participating more fully in the labour market were simply too high. Caring for a disabled child is typically a very rewarding experience and one that families clearly value. Most actively choose to care for their children almost full time. Many families would prefer to limit their employment choices rather than limit their ability to care for their children, a choice that is hard simply to characterise as creating barriers in terms of access to work. This means that for some families no 'incentives' to work will result in them working – or at least working full time. This is, of course, also a choice that many white British parents make.

Access to services and cultural preferences

As with childcare, one of the key questions in our research was how and whether our interviewees accessed existing services. This was addressed in terms of both the information or knowledge they had about existing services and their preferences or priorities concerning the kind of care they received. Two key questions on this latter issue were whether or not they preferred care at home (addressed in the previous section), and whether or not they preferred a carer from the same ethnic or religious background.

Our findings about people's use of services were mixed. Somali and Pakistani respondents generally had less uptake than Caribbean people, although our sample size was very small and we did not have a white comparator group. In general, lack of uptake of services was more because of a lack of knowledge or information than because parents rejected the services on offer. This was observed where parents were unfamiliar with some benefits but did not cite an experience of discrimination or other reasons for rejecting services. This accords with existing literature that ethnic minority groups are less likely to take up benefits to which they are entitled, both generally and in terms of disability (see Barnard and Turner, 2011). Evidence further suggests they are less likely to be aware of and take up services around disability (see Trotter, 2012a, among others).

Interviewer: "Do you feel you know about all the support available for you from the council and central government?"
"No I don't ... I just don't want to say I do know for the sake of it."

Pakistani woman (3 children, one with polio)

Interviewer: "What support do you currently receive from your local authority or other agencies in looking after your child?"
"I am not getting anything ..."

Pakistani woman

It is perhaps too sweeping to say that these sentiments reflect a wider lack of awareness of services in general, although many respondents in the research did appear less aware of available services, as we explained in Chapter 4 on childcare. Support for disabled children is fairly complicated, with a variety of schemes and kinds of support (cash benefits, in-kind support, support from health and social care workers), and our interviewees were often uncertain

if they fully understood or had access to everything on offer. Research suggests this is relatively common: 56 per cent of respondents in a previous survey felt that their isolation was due to lack of support from statutory services such as social care and education services (Contact a Family, 2011). Furthermore, it is not simply the case that people do not know about services; in some instances adequate services do not exist. The Daycare Trust (2012b) suggested that 13 of 32 London boroughs did not have suitable childcare for disabled children in 2011.

While they represent only a small part of our already small sample, there appear to be particular difficulties for some mothers caring for disabled children when they have divorced their husbands. In cases where the mother was born overseas (for example, in Pakistan) she may be relatively reliant on her husband and his networks and family for accessing services, and may have limited independent contact with local authorities or other state agencies. This obviously poses a difficulty if these women get divorced, and one of our interviewees expressed concerns about whether she was accessing all the services and receiving all the benefits to which she was entitled.

In fact, family breakdown is unfortunately relatively common among disabled families, and so the above sentiments may not only be due to 'cultural' considerations. Of families with disabled children, 1 in 5 experience family breakdown, and many report that this is exacerbated by the isolation they experience (Contact a Family, 2011). This isolation was mentioned by all the communities we interviewed.

While evidence suggests that many parents caring for disabled children feel isolated, there are further reasons that migrants and some ethnic groups may already be more isolated or less well connected with social networks in Britain. Previous research has suggested that high rates of unemployment among Somalis can generate a 'cycle of depression, isolation and poverty, and ultimately turning to khat use' (CLG, 2009). We did not fully explore this last question, but did hear significant evidence of isolation. For example, some mothers expressed concern about racism or Islamophobia in public spaces, which resulted in their being less likely to visit or travel to parks or nurseries by themselves or with their children.

For some people, their level of spoken English appeared to be a barrier to uptake of services. At the same time, one blind Somali participant expressed confidence in the skills of her support worker, and in additional support she received from another carer in caring for her children, even though only her personal support worker spoke Somali.

Relatively few of our interviewees expressed a strong preference for 'ethnic matching' between carer and disabled child. This contrasted somewhat with our findings for childcare and for caring for older relatives. Parents often felt that experience and knowledge were much more important than cultural awareness or competence in providing the specific and tailored support their children needed. Furthermore, even when respondents felt that it was important that carers take into account religious or cultural concerns, they generally agreed that their carer was able to do so. If a carer needed to be asked to take off their shoes on an initial visit to the home, most of our interviewees felt that carers were relatively well trained to take these sorts of consideration into account.

Interviewer: "Do you feel that people are aware of, say, the need to take off shoes on entering a house?"
"No, that hasn't been a problem ... I mean sometimes people might not know about taking off shoes the first time, but after

you explain ... it's not a big deal and people do it without asking or any trouble."

Somali woman

The final issue that arose in terms of access to services was the question of whether a child received an appropriate diagnosis or assessment by the local council. In the Somali focus group a few parents gave examples of parents who felt their children were not given a proper assessment and diagnosis, and that as a result they did not receive sufficient care. This was especially the case for special needs assessments, and while interviewees did not explicitly state that racial discrimination affected these assessments, they did appear to think that white children were more likely to be appropriately diagnosed. Black and minority ethnic families may also need more support in understanding a diagnosis, particularly if they do not speak fluent English or are newer migrants. This is obviously a somewhat sensitive area, not least in the context of the over-diagnosis of mental illness among black men, but it is one that obviously affects parents' ability to enter the labour market without the support provided following a special needs assessment – they must then find more time to support their children themselves.

"I mean he was behaving differently ... He wasn't talking very well ... He wasn't engaging with other kids ... He used to be in his own little world ... Then I took a step forward and contacted the GP. He was referred to see a specialist and soon we found out he had autism. It was a shock for me ... I didn't know what autism was. I had never heard that word in my life before ... then I was told by the doctor that it's not a disease ... your kid has special needs and needs little bit of extra support to learn day to day things ... What other kids of his age learns automatically from copying their friends or parent or brothers and sisters your child will need to be taught ... So I used to teach him if we meet somebody we say 'Hello'. When they leave we say 'Bye'. Those sorts of things he couldn't learn himself"

Pakistani woman

Attitudes to disability

One of the more sensitive questions on disability and ethnicity is whether different groups have different attitudes towards disability. There is some evidence that there may be a greater sense of 'shame' or 'stigma' of disability in some ethnic minority communities, and this may explain the low rates of self-reported limiting illness, particularly among Chinese people, and (perhaps) the lower uptake of services for Pakistanis and Somalis.

In addressing the question of stigma or shame, we should distinguish the attitudes of parents from those of the wider community. In general, parents with disabled children did not have serious issues about shame or stigma personally, and rather expressed love and concern for their children, as we might expect from any parent. A Caribbean participant explained how this experience of a family member could change attitudes.

Interviewer: "How are the general attitudes towards children with disabilities informed?"
"People who have a close family member or friend have different views than those who haven't ... and their attitudes change accordingly ... Mostly people are more sympathetic according to me ... Of course I may be wrong but this is what I have experienced ..."

Caribbean woman

The Pakistani parents we interviewed did express some concerns about how the wider community responded to their children's disability. This was also true for parents who did not have a child with a disability, and indicates that some work is still necessary to overcome stigma in at least some parts of the community.

"In our culture children with disability are seen as a weak and helpless ... Everybody will try and take advantage of their situation ... It's also seen like it's a curse ..."

Pakistani respondent (no disabled child)

"I would feel happy if we can somehow spread awareness amongst people in our community that children with special needs are not harmful... and they not going to pass their disability to their kids"

Pakistani respondent (with disabled child)

For some parents of disabled children, their bigger concern was to ensure that their children had sufficient care, and that this could reduce the amount of time available for socialising outside the family. A Somali participant, whose adult son suffered from depression, again did not necessarily self-describe as a 'carer' but rather talked about 'normal' activities that were necessary for the whole family or household.

"For my family it is the normal things, buying food and anything else they need, paying for rent and bills, and just making sure everything is OK, for my son I also have to talk to him, make sure he takes his medicine on time and make sure he doesn't do harm to himself when he is feeling very bad"

Somali man, 48

Another Somali mother suggested that while caring for a disabled child constrained her interaction with the wider community, this was less to do with shame or stigma, and more to do with time, costs and geography.

"I really don't go out much and would like to. I don't see my friends very much and most of my family live in Africa. I cannot go to see them because it costs too much. I don't really do much apart from looking after my children"

Somali woman

Among almost all interviewees, there was a strong sense that their family and community supported them in caring for their disabled children. There were, however, concerns about their ability properly to provide for their children. This relates to our discussion above, where many parents worried about their income levels and the effect this had on their ability to care for their children and offer them the best opportunities. Although a single Pakistani mother had perhaps a more difficult situation and more limited income than most of our interviewees, her sentiments reflected the concerns of many of them.

"Everything is becoming so expensive and only help I get from government is Disability Living Allowance and I don't have to pay council tax ... I bought this flat as a part of shared ownership ... It is part buy and part rent. I get some help from council to pay my rent but there are millions of other things you have to pay for ... like electricity bill, water bill, food, clothes, books, stationery etc."

Pakistani woman

Previous research has considered the role of religion, including Islam, in terms of attitudes to disability. We did not really find that Islam as such informed attitudes towards disability in a negative light. Many mentioned that Allah had some role in the determination of their children's experiences, but most felt this meant that Allah would judge how loving and caring they had been to their children and, if anything, show them greater preference and concern. Some interviewees did mention that others might think that Allah was 'punishing' them, but that this was a minority view, and most felt Islam was a positive resource in responding to their children's disability.

We did find one case, however, where a parent seemed unable or unwilling to address his child's disability. In this instance, however, the mother of the child chose to divorce her husband, who had blamed her for the child's disability. There is some thought that this may be influenced by religious beliefs among some Muslims (and others) who believe disability is God's will, although interestingly it also appears that those who blame their wives invoke modern scientific concepts such as genes. While this is not exactly a common phenomenon, it is one that affects some ethnic minorities, although it seems to occur much less among Black Caribbean families.

In general, then, we found very little evidence that parents themselves experienced shame or stigma in caring for their disabled children. Where this issue arose somewhat more was in the case of other people evaluating their children or their level of caring. Close-knit social networks can be good for a community if people are less familiar with social institutions or public services, or where discrimination or social exclusion is a barrier to their participation in society. But those same networks are frequently based on people knowing each other very well, and among our interviewees people spoke about 'gossip' as a concern, especially where a child or family member is disabled. This made it even more difficult for parents with disabled children to socialise outside the home.

Both parents and others felt that in general communities supported people with disabled children, and there was agreement that negative attitudes or behaviour towards disabled people was increasingly unacceptable. Among Caribbean interviewees, these concerns almost never arose, although one interviewee did mention it as something that had happened in the past. Among Pakistanis and Somalis, our evidence suggests that a similar development is occurring within these communities: previously closely-knit communities may have negatively discussed a child's

disability, but this was now becoming somewhat less common. In some ways this indicates a change in perspective within these communities, although the effect of community gossip is also now limited as communities are less closely-knit. For some interviewees, this was a mixed development: while they appreciated the lesser impact of stigmatisation of their children, they also felt a loss in terms of the kind of community they grew up in. This was most commonly mentioned among Pakistani interviewees, although Somalis also mentioned this loss, especially in the context of fewer older people and aunts and uncles being present to maintain traditional practices.

A few Pakistani interviewees mentioned one final way that a child's disability affected their interaction with the wider community. This related to marriage. Here, the concern was that if a family had a disabled child, it would be difficult to find a marriage partner not only for that child but for their siblings too. One respondent suggested that this would be less of a concern if the first-born child was not disabled, and indicated that stigma and shame continue to have significant effects in at least some situations.

Although our respondents did not agree that they would prefer a carer from the same ethnic background regardless of their qualifications or skills, some did note that it would be good if more Pakistanis or Somalis were formally trained to care for disabled people. This was often expressed in terms of language, but also in terms of cultural awareness. As we have noted, respondents felt that existing carers were able to meet most of these requirements, and some rather emphasised that having more Somali or Pakistani carers would improve understanding of and attitudes towards disability within the wider community.

Our findings suggest that while stigma or shame about disability are not wholly absent among Caribbean, Pakistani and Somali communities, they are not as prevalent as cruder analysis would suggest. Existing research findings on different attitudes to disability by ethnic group are somewhat mixed, with some researchers arguing that religious or cultural beliefs may shape their experience and understanding, but do not affect their access to services. For example, Bywaters, *et al.* (2003) suggest that 'institutional racism' better explains any reduced access to services, and also that Pakistani and Bangladeshi parents of disabled children have limited interaction with the 'disability movement'.

While stigma or shame about disability are not wholly absent among Caribbean, Pakistani and Somali communities, they are not as prevalent as cruder analysis would suggest.

Here it is worth highlighting that up to half of all families with disabled children report discrimination or stigma (Contact a Family, 2011). While there are, of course, different cultural expectations, preferences and values when it comes to caring generally, and caring for someone with a disability in particular, these are clearly not limited to ethnic minority groups. Whatever actions we take to reduce discrimination and stigma associated with disability generally are therefore likely to benefit the families we interviewed in this research.

Conclusion and implications

Caring for disabled children is an experience that parents deeply value. At the same time, this caring shapes the opportunities and hence the choices parents can make in terms of their engagement in the labour market. Four headline points emerge from our findings. First is that, like other disadvantaged groups, ethnic minorities are more likely to live in poverty, and this of course makes it more difficult for ethnic minority carers with disabled children to balance work and care.

More specifically, the particular experiences of black and minority ethnic people generally in the labour market and in terms of household structure pose particular challenges for black and minority ethnic households with disabled children. Of lone parents, 3 in 10 (29 per cent) have a sick or disabled child and only 50 per cent of disabled children receive Disability Living Allowance (DLA). These findings do not explicitly apply to ethnic minorities, but they do suggest that those groups with higher lone parent rates (including Caribbean and Somali households) are more likely to have sick or disabled children, while the already lower rate of benefits uptake among South Asian groups in particular may mean that disabled children from these ethnic backgrounds are even less likely to be getting DLA.

Similar interpretations apply to higher female inactivity rates among ethnic minorities. This greater prevalence of economic inactivity may be compounded, given that a child's disability has a negative effect on paid work both for lone parents and couple mothers, with the impact strongest for mothers of disabled children rather than fathers. That is, if ethnic minority women are already more likely to be inactive regardless of family structure, those who have a disabled child may be particularly unlikely to participate in the labour market.

A second key finding concerns how policy on disability interacts with other policy areas, and not just in terms of labour market participation. A key interaction is childcare. Appropriate childcare for disabled children is scarce and expensive. Platt's research for the Equality and Human Rights Commission (EHRC) (2009b) found that nearly half (49 per cent) of family information services in both England and Wales reported that there was not enough childcare provision in their area for disabled children. With fewer childcare options, families with disabled children are much more likely to have one or other parent stay at home to cover childcare requirements. Given that many ethnic minority groups (although not Caribbean people) are less likely to use formal childcare services, they may be particularly unaware of support for disabled children and the benefits such childcare provides.

Third, we have suggested that ethnic minorities may have some slightly different or particular needs or preferences. Although these do not extend to preferring a carer who is always from the same ethnic or religious background, there is a need to capture and expand existing good practice on providing culturally competent care, and at least some language provision, so that ethnic minority disabled children are not further disadvantaged. This was not a major concern for many of our respondents, but our sample size was very small and all were based in London, in areas with large numbers of residents from their ethnic minority community where services are well tailored to respond to their needs.

Finally, in some ethnic minority communities more work is necessary to raise awareness about disability, and to combat any stigma associated with disability. While this is sensitive work, it is necessary to ensure not only that parents are better able to balance work and care but also that disabled ethnic minority people are able to live more independent lives with dignity. Generally speaking, our recommendations for families with disabled children focus on better information, advice and support, including culturally competent care where possible.

6 CARING FOR OLDER PEOPLE

The final caring situation we address in our research is caring for older people. Our main data source for this was a large survey conducted by Brunel University, and follow-up interviews for that project.

As we explained in Chapter 3, all ethnic minority groups in the UK have a younger age profile than the white British population, and only the Caribbean community has a large over-65 population, but there are particular caring preferences among the three groups we interviewed that in many ways resonate with our findings in previous chapters. Around one-third of carers are caring for a parent or parent-in-law, so these experiences are obviously a significant aspect of caring among ethnic minorities in the UK.

The prevalence of caring among ethnic minorities

In Chapter 3 we highlighted national data on caring and indicated some of the definitional questions regarding the nature of caring. There is some data on the extent of caring among ethnic minority populations. A recent report by Carers UK entitled *Half a million voices: improving support for BAME carers* (2011b) estimated that there are 503,224 black and minority ethnic carers in England, representing 10 per cent of all carers. Indian carers are the largest minority ethnic group in terms of numbers of carers.

The 2001 census provides broad estimates of caring across ethnic groups. Focusing on those caring for 20 hours or more per week reveals that the highest prevalence of caring is among Bangladeshi and Pakistani adults, with rates among black people approximately the national norm (see Table 5). These figures focus on those providing the most intensive care.

Table 5: Prevalence of caring for 20+ hours per week by ethnicity (%)

	Ethnic group					
Type of care	**White**	**Indian**	**Bangladeshi**	**Pakistani**	**Black African**	**Black Caribbean**
Caring 20 hours+ per week*						
Male	3	4	4	4	2	3
Female	5	6	8	8	4	5
All	4	5	6	6	3	4
Self-defined informal carer**		22	18	17	9	12

* Source: 2001 census
** Source: Victor, *et al.* (2014) survey of ethnic minority carers in England and Wales, whose numbers are larger because of the targeted nature of the sample

The 2009/10 survey of carers as part of the General Household Survey provides estimates of caring by three broad ethnicity categories: 'all Asian', 'all black' and 'other'. This data indicates that 10 per cent of black and minority ethnic adults are carers (6 per cent in the same household and 4 per cent in other households or as 'extra-resident carers') compared to 12 per cent for white households (with 6 per cent each in the same household and in other households).

There is a difference in the prevalence of caring between the two main specified ethnic groups in terms of the prevalence of caring overall and caring for the person they live with. Overall 14 per cent of Asian adults self-defined as carers (9 per cent as resident carers) as did 7 per cent of black adults (4 per cent as resident carers). Thus we see both a higher prevalence of caring than the national average among Asian adults and lower rates among black adults, confirming a pattern identified by Victor, *et al.* (2014). Of special note is the higher prevalence of resident caring among the Asian groups. However, if we look at carers in the UK overall, only 10 per cent are from minority groups compared to 14 per cent in the population overall, although this represents an increase from the 6 per cent reported in the 2001 census. The seemingly lower prevalence of caring among ethnic minority groups may also be a result of their younger age profile: while around one in five white British people are over 65, only one in thirty Bangaldeshi people are, and less than one in ten Indian people.

One obvious area for research is how people determine what is (and is not) a 'normal' family relationship and when 'normal' becomes caring. Some of these issues are explored in our qualitative data, including in previous chapters. There are gender and age differences among informal carers, in addition to the ethnicity considerations explored in this research. In each of the surveys and both censuses a higher percentage of women than men defined themselves as carers, and Carers UK (2009) suggests that 58–79 per cent of carers are women. We also see that the highest percentage of adults self-defining as carers is in the 45–64 years age range, and Carers UK suggest that half of all carers are between 40 and 54.

Turning to employment, 10 per cent of adults in employment are carers. This is not unexpected, given the age and gender profile noted above, although Carers UK has suggested that 37 per cent of people caring have given up work to do so, and 26 per cent care full time.

Informal caring and ethnicity

A key aspect of research and policy on older people and those with long-term care needs across the age ranges is the provision of 'informal' family-based care. Most long-term care needs are managed and experienced within the family setting. Informal care may be broadly defined as that provided by family, friends and neighbours which is not organised via a statutory or voluntary agency.

Informal care is often conceptualised as being part of a wider definition of family care, characterised as 'caring when one or more family members give aid or assistance as part of the "normal"' (Walker, *et al.*, 1995). Such care and assistance is not provided directly for money; nor is it wholly viewed as a matter of individual choice, but rather stems from the complex relationships of responsibilities and obligations that arise within families or long-term friendships and relationships. Informal care is not always easy to define precisely and may, of course, vary among different types of household or generations, as well as for different ethnic minority groups.

In Chapters 2 and 3 we explained the various challenges in precisely defining informal care, including the often gendered nature of such definitions: that is, women are more likely to provide such support but less likely to characterise their support for family members as 'care'. The participants in our qualitative interviews fairly clearly distinguished normal family care from caring when talking about their role with either their disabled adult children or older relatives.

"We have long talks about how he is feeling nearly every day, as according to his doctor this is one of the best ways of making him feel better ... I cook all his meals and clean his clothes but I don't count that as caring because I do it for my husband as well! Ha ha! But the days he is feeling very bad I spend all day looking after him because I have to tell him to do everything and he has bad days probably 2–4 times a week"

Pakistani woman, 53

As we have explained in the previous chapters, there is often an assumption that people in ethnic minority communities are more likely to prefer caring within the family – and even within the same household unit. This may link to historical practices of 'joint family' homes, particularly in South Asia, although it is notable that these practices are declining even in India, Pakistan and Bangladesh.

However, despite these changes in expectations, it still appears that South Asians are more likely to be carers and to provide care to older family members in particular. This raises a key policy question, namely the reasons why people 'care'. The 2009/10 survey of carers reports that expectation and family norms and practices were the primary motivations along with a willingness to help, which is probably interlinked with the notion of family norms (see Table 6).

Table 6: Reasons for caring – 2009/10 survey of carers

Reason	Percentage
It was expected for me (it's what families do)	54
I was willing/ I wanted to help out	53
He/she would not want anyone else caring for them	15
No one else available	12
He/she is a family member	8
I had the time because I was not working	7
Cared for person requested my help/care	4

Source: 2009/10 Survey of Carers

As we have already indicated, across the three caring contexts included in our study – childcare, caring for a disabled child and caring for an older relative – participants in our qualitative interviews clearly saw the family as central to the provision of care. While this obviously applies for those caring for their children, we found substantial evidence that the ties of family were particularly important for caring for older relatives – and not only parents.

"I don't rely or expect anyone else to provide care for me... Or for my parents"

Caribbean man, 50

"I think that there is very little that can be done to make caring for my father and son any better because I believe I am giving them the best care that anyone could give them"

Caribbean woman, 44

"I care for my niece and mother because it's family. You have to be there for family. It's a shame if we were not there for family when they need our help the most ... sometimes I'm busy but I am willing to help"

Caribbean man, 48

For these participants – and regardless of context – caring was simply what families do. Our qualitative interviews capture the complexity and range of reasons why individuals cared, including the nature of the relationship with the dependent, cultural expectations, religion and a sense of personal responsibility, as well as helping out when primary carers of children were unable to provide childcare.

"I didn't have to ask my family to care for me and my husband didn't request my care – it's my culture and tradition which is responsible"

Pakistani woman, 67

"I think culture plays a big role. We are Muslim and ... in Pakistani culture a man is the head of the household ... he ... provides financial support ... Even when I started providing support to my wife ... I was criticised by some typically Pakistani males that 'Oh why you doing all these for your wife? ... It's not you who should be doing all these'"

Pakistani man, 70

As the above quotation indicates, in Pakistani and Somali families in particular there are fairly strong gender norms about caring, and these are reinforced throughout the lifecycle. That is, sons and daughters have different expectations when they are younger, but also when they are older, including around how they should provide or receive care. This may be viewed as either an opportunity (women are more able to care while men are not) or a constraint (women are expected to care while men are not) that affects how people choose to care, and of course their opportunities around work.

"In our culture traditionally this has been the way it has always been: a son stays with his family; when he gets married his wife moves in with his family, which means that now she has a responsibility to now look after and care for his family – they now become her priority, her priority has changed from her own family to her husband's"

Pakistani man, 66

"Well I think it has more to do with how my mother raised me and the lessons she taught me because she was always looking after my father especially during his final years, which helped show me what it means to be a mother and a wife and what caring for someone really is, because she spent hours washing, clothing and feeding him, which is why I never feel angry about having to look after my son because my mum had it much worse and she still looked after everyone else in my family"

Pakistani woman, 52

Many of our Pakistani and Somali respondents also mentioned Islam in various ways in explaining their attitudes about caring. Sometimes this was part of a wider discussion about their cultural background and values, while occasionally respondents provided fuller explanations of why Islam required people to care for their parents.

"I was born in England but my Pakistani background played an important part in my life like teaching me about being good to others, but I think most of them things came from Islam not being Pakistani, but more because we were Muslims and a teaching of Islam is heaven lies at the feet of your mother, which means one who is good to his mum will go to heaven so it gives me a greater motivation to do what I do."

Pakistani man, 44

"I am Muslim ... in Islam looking after family is very important"

Somali man, 70

In general, caring does not get adequate policy attention (or resources), and informal caring is perhaps particularly unlikely to get such support. Yet as we have shown, research consistently demonstrates that family members support one another throughout the UK, often in a full-time capacity and without adequate emotional, financial or health support themselves. Many have therefore called for more support for 'informal' carers, for example through 'domiciliary care' in people's own homes. This can include help with cooking, cleaning or more clinical support. The key policy agenda here is 'personalisation', namely allowing individuals to choose the kind of care that best responds to their needs. This may be linked to the 'independent living' agenda, which envisages a more positive social care environment for those needing care to receive it in their home and in a way that better allows them to continue to live their life as they see fit.

We assess the opportunities for personalisation in the conclusion, Chapter 7, but it is worth noting that our research participants could clearly benefit from this development, if implemented successfully. To the extent that different groups prefer different kinds of care, and that some such support could be financially supported by local authorities, this would obviously improve the quality of care provision for older ethnic minority people and support their family carers. As we suggest, this depends on adequate knowledge of these services on the part of families, as well as an appropriate supply of care options to meet the diverse preferences of the UK population. More broadly, however, policy-makers must think harder about how to support carers in the home, as this is the most common form of caring, and one that families typically prefer. At the same time, this caring creates significant challenges for families, especially those with limited resources or resilience – and not only in terms of the labour market.

The consequences of caring, and the role of choice

A range of consequences has been identified with the provision of informal care. These consequences are often well understood by carers before they begin caring, especially if they are positive. Many carers notably emphasise the positive benefits to caring, especially in terms of fulfilling religious obligations, spousal relationships or filial responsibilities.

"As a religious person it is also very important to care for the sick and less fortunate and I also get a good feeling when I do it because I am helping him and I'm probably the only person that can do it because the rest of my family are busy"

Pakistani woman, 52

One issue raised by the notion of obligation or responsibility is whether carers thus view their caring as a 'choice'. People do not simply make choices in the world regardless of their prior values and beliefs, or independently of how these values and beliefs inform their sense of self. The key point is that it is important not to view familial obligations simply as 'constraints' or to see these responsibilities as barriers to the labour market, as this is not the best way to characterise the way carers live their lives – and indeed make choices.

An alternative framing to that of opportunities and constraints is to highlight how a person's values and beliefs and their resultant sense of self provide a context for choice.

A range of negative consequences has also been reported among carers, although respondents may not always be willing to report these or view them as constraints they can choose to ignore. In surveys, the most common negative consequences relate to health status (both physical and mental) and reduced quality of life, with 52 per cent of carers agreeing that caring affects their health in the 2009/10 survey of carers. Some of our respondents explained how caring had negative effects on their health.

"It has affected my health in some ways – I am fatter, I eat late because [she] eats when she is up, usually late and I am a bit paranoid thinking about the future ... but even the present is stressful because I have to be close to the phone. I don't have many friends and those that I do meet are her friends"

Caribbean woman, 44

In addition to health effects, the other main negative consequences of caring found in the survey are restricted social lives (reported by 42 per cent) and employment opportunities (reported by 26 per cent). We address the question of work in further detail below, but some of our interviewees also commented on the restriction on their social lives, including the need to plan social or other activities.

"I plan my life around her so sometimes it can be a bit annoying that I can't go out with my mates because I have to take her somewhere but what can you do: she has to take priority. I enjoy knowing that I am helping my mum, she spent all them years raising me so it's only right if I do the same. And least enjoy not being able to do things because I am busy looking after her but it's only a little thing"

Pakistani man, 70

"The only negative thing which I can think of is being on 24-hour call ... I cannot go out or visit my family or friends but it means that if I do venture out I can only do it at a certain times of the day and I also have to make ensure that I always have my phone on me and that it's charged just in case of emergency"

Caribbean woman, 44

"But to be honest I don't get to see my friends that much ... I used to stay in the mosque till late and come back home at 11–12 pm but I can't do that anymore ... so it has little impact on my social life but it's not a big deal"

Pakistani man, 70

Caring and work

Caring often has a negative effect on carers' interaction with the labour market, with more than 1 in 3 in the wider population leaving their jobs. In the survey by Victor, *et al.* (2014) only 5 per cent of the Pakistani and black African carers were employed, and while few participants had left work to fulfil caring duties, this was largely because few were employed beforehand.

Our research also included a quantitative element that contained a question on whether carers were working. In the ethnic minority sample only 18 per cent were working (N=115), while in the white sample around twice as many (36 per cent) were working (N=1494). These differences cannot be based solely on gender: 42 per cent of the ethnic minority sample and 40 per cent of the white sample were men. This data clearly suggests that ethnic minorities are much less likely to be in work (see Table 7).

Table 7: Working status among carers by ethnic group

Status	White	Ethnic minority
Working	923	21
% within ethnic group	*38*	*18*
Not working	571	94
% within ethnic group	*62*	*82*
Total	1494	115

Note: Working status $X^2(2, N=1609) = 83.40, p<.001$
Source: University of Brunel research for this project

One key finding that emerged in our greater range of interviews on caring for older people was the value of flexible working. For a number of respondents, the flexibility of their employers was crucial, as was organising their working lives to mesh with the needs of their dependent.

"I am quite lucky in some ways because as I mentioned before I work for [the] council and they are quite flexible with me. I am able to give both my father and son all the attention and assistance that they need"

Caribbean woman, 44

"The only issue which I have is having to work around [her] sleeping patterns because she gets up at about 5pm and goes to bed at about 2am; therefore, as I am working from home I always make sure my work is completed by 5pm and I then I will try not to arrange too many social activities between 5pm to 2am, which means that I do not really go out that much"

Caribbean man, 50

Access to services

As with childcare and caring for disabled children, there are questions about how far people know about existing support services for carers for older relatives, and whether they feel those services are appropriate. The 2009/10 survey of carers reported that 6 per cent of carers had been offered a carers assessment.

This data, as well as data that black and minority ethnic people are less likely to access benefits and entitlement, probably indicates that ethnic minorities are less likely to take up Carer's Allowance. Carer's Allowance is the main benefit for carers and in 2014 the weekly rate is £59.75. While carers are estimated to save the economy £119 billion per year (or £18,000 per carer), the £59.75 Carer's Allowance comes to only £1.71 per hour for 35 hours of caring per week, compared to the minimum wage of £6.31.[13] It is hardly surprising that many carers report difficulties paying utility bills or mortgages and half get into debt as a result of caring, experiences that may be even more common among black and minority ethnic carers, given their lower incomes, lower savings and higher unemployment rates.

Another important question is whether ethnic minorities meet all six conditions required to receive Carer's Allowance.

1. You look after someone who gets a qualifying disability benefit.
2. You look after that person for at least 35 hours a week.
3. You are aged 16 or over.
4. You are not in full-time education.
5. You earn £100 a week or less (after deductions).
6. You satisfy UK presence and residence conditions.

We anticipate that many ethnic minority older people may not be receiving qualifying disability benefits, not only harming their own levels of support and well-being, but also preventing their carers from being entitled to Carer's Allowance.

One service that participants appear to have better contact with is the NHS, and medical services generally. This often appears to build on prior experience of and relationship with medical services, especially among our Pakistani respondents.

"I see my doctor quite regularly and I probably should see her more often but when you have two daughters who are doctors and the other three children are dentists it is very difficult for me just to rely on my doctor"

Pakistani woman, 67

"He visits the doctor every fortnight to see how he is doing and how effective the medicine is, and the doctor also gives me advice on how best to talk to him and stuff"

Pakistani man, 44

"I go and see my doctor at least once a month for a check up to make sure that my sugar levels are not too high and to check that I am following the correct diet"

Pakistani man, 66

However, while participants were often familiar with formal medical services, they rarely reported other forms of statutory support. This reflected a lack of knowledge or information, as raised in previous chapters, but also a lack of trust in such services, with some also reporting potential shame in asking for help. Although this might be expected to be higher among Somalis as more recent migrants or among those Pakistanis who don't speak English, we also found these views among our Caribbean respondents.

"I don't use any of these [list of example services read out by interviewer] I didn't realise that any of them available"

Somali woman

"Well she is my mum so what kind of person would I be if I didn't take care of her like she took care of me, and I am the only one of my brothers that doesn't have children so I have more room in my house and more time to look after her. But to be frankly honest I wouldn't trust anyone else looking after ... I am the only one who knows her properly like it would be hard for someone to know how warm to make her tea or how many cushions she needs to sleep on or what time she likes to be woken up and things like that. I am the only one who knows that stuff so letting someone else look after her is not right"

Pakistani man, 44

"It's good to have proper services so that old people like my mother can proper get to know what is out there for them ... I don't know where to look to be frank and because we are family we don't bother about them council thing. I know ... there would be lots of forms and trouble to go through"

Caribbean man, 69

"If I had easier access to information regarding how best to look after my mum and stuff like that it would help because now if I am not sure whether something is serious or not I have to go to the doctors, whereas it would be much easier if there was another way of finding out like a reliable internet page or a hotline"

Pakistani man, 44

"Sometimes if you have carers in your home it is seen as a big shame for the family ... people think we cannot cope or we are lazy and don't want to care for [our relative]"

Somali man, 48

As with childcare, and somewhat in contrast to parents with disabled children, more of our respondents, particularly Pakistani and Somali respondents of all ages, suggested they would prefer services to be culturally appropriate, or even culturally or ethnically matched. A notable case was

a Pakistani man who suggested that he would be much more willing to be satisfied with a care home for himself if it catered to his needs as a Muslim, and indeed catered to Muslim residents generally.

"I would be happy if I could get someone from my background or culture who could visit me to give advice relating to my diabetes because it is not always easy to visit my doctor because of his schedule and although I am grateful for his advice ... I don't always think that I get the best advice or alternatively if there was a telephone advice line I could use. I know I don't like the idea, but there is some need for Muslim care homes, that give all the facilities that make the older person feel comfortable culture wise. I don't feel comfortable with being away from my home, but if I had no choice I would consider such a possibility. But I will not want to be in a setting which is all English as I will feel alone"

Pakistani man, 66

In previous research we discussed the issue of care homes (Khan, 2012), and one of the key questions in that report was whether the supply of culturally specific care homes meets the likely demand. This is partly because the current older generation was almost entirely born overseas (someone who is 65 was born in 1948, the date that usually marks the beginning of postwar migration), and this is the generation that is most likely to have culturally specific needs. However, this is also the generation that has the highest expectations that their children will look after them, especially among South Asians, including Pakistanis. If the next generation also has different needs or preferences, perhaps Muslim communities in Britain will follow Jewish communities in establishing some community-specific care homes. However, for the moment our understanding is that there is insufficient demand to support greatly expanding the supply of such homes, at least according to two individuals who were involved in increasing the supply of care homes for Asians in Britain.

The above discussion applies primarily to Asians. Among Caribbean people it might be thought that 'culturally specific' care is less necessary. However, as shown in Khan (2012), there are a number of concerns among Caribbean older people which resonate with many other ethnic minority groups. First is the issue of food. While this may seem somewhat incidental, respondents noted that 'food is fuel' and that inadequate food would have effects on their health and well-being. Respondents did not necessarily expect Indian or Chinese food every day, especially if a home had few other residents from their background, but they did prefer to have it at least weekly if not more.

Another key concern is the social environment in mainstream care homes. For those who do not speak English, it is obviously a problem if television programmes and social events are exclusively in English, but we also found cases where Caribbean people were concerned about the social environment in care homes where they were the only black residents. The very fact that most Caribbean people self-identify as British and often have positive memories and experiences of their social life in the UK can be a difficulty if they end up in a care home where the social references and experiences do not reflect their own. One relatively simple way this was expressed was in terms of the photos or painting on the walls, while a more serious one concerns the use of memories to stimulate older people, especially those in the early stages of dementia (Botsford, 2011). If older

Care for older people within the participant's country of origin was perceived to be better than in the UK.

Black Caribbean people have different memories, do not recall particular historical moments or songs prior to their coming to the UK, or even if their memories involve experiences of racial discrimination, they may not share in the positive collective experience of white British residents.

Another interesting finding was the notion that care for older people within the participant's country of origin was perceived to be better than in the UK (a point that the Health Secretary Jeremy Hunt has also recently argued). The perception or 'imagined' idea of care was that families cared for each other personally, as opposed to the notion that older people in Britain were consigned to care homes by their families and that this was also a strategy being adopted by some minority communities. This was not limited to South Asian groups, as the following quotations indicate.

"In England a lot of families put their parents in care homes which is something I wouldn't never dream of doing so I don't think my country of birth has really influenced my view on this that much"

Pakistani man, 44

"When I become very old and unable to look after myself that my family will put me in a care home because unfortunately this is a cultural issue unlike Indian and Pakistanis families, Caribbeans tend to put their parents in to care homes rather than taking responsibility of looking after them themselves therefore I do hope my children take my example because that is another reason for caring"

Caribbean woman, 40

"Culturally looking after someone who is ill is common in Pakistan as you often find people, especially girls, looking after their father: it is seen as an important job as their father raised them so they have to help him when times are hard, and it is the duty of the children to look after the parents when they get old so it is a common thing"

Pakistani woman, 52

"One thing is clear – it is better that they are in Grenada than here. The old people don't get looked after here in England"

Caribbean man, 50

Conclusion and implications

At present Somalis have relatively few older relatives, but they appear to follow Pakistanis (and other South Asian and black African groups) in preferring to use 'informal' care, or to ensure that older people are cared for by family members. Caribbean people appeared more comfortable with 'mainstream' care, although they too raised concerns about the appropriateness of some services.

As with the UK population generally, our participants were much more likely to engage in 'informal' caring, or to provide care within the family, and

in the home. There is a need for policy-makers to support this sort of care much more, and to make personalisation a reality for disadvantaged ethnic minority groups. In the conclusion we suggest how this might be done (see also Carers UK, 2007; Carers UK, 2011a).

In terms of balancing work and care, very few of our respondents were in full-time employment, with relatively few even working part time. While this often stemmed from an increase in caring responsibilities, many respondents had poor labour market experiences even prior to this, which again suggests that many of the barriers for people to balance work and care stem from wider difficulties in the labour market. Whether these are explained in terms of discrimination; migration status; low skills, qualifications and experiences; or language competence, ethnic inequalities in the labour market have wide-ranging effects on many policy areas, including caring.

As ethnic minority communities increase in size and progressively age, the consequences of these poor labour market outcomes will become more severe. In the conclusion we again suggest how policy-makers could better respond to the experiences, needs and preferences of ethnic minority carers, but one key point is that more flexible working and higher wages are likely to make all carers better able to frame their caring as a choice within a reasonable set of opportunities.

7 CONCLUSION: POLICY IMPLICATIONS AND RECOMMENDATIONS

In this chapter we bring together the findings of the previous chapters and place these in relevant policy contexts to explain and justify our recommendations. These recommendations generally seek to reform how policy is delivered so that it does not worsen ethnic inequalities, and, more ambitiously, to improve the position of ethnic minority groups.

If current reforms to welfare, employment policy, caring and disability do not respond more nimbly to the experiences of ethnic minority people they are likely to exacerbate ethnic inequalities. The evidence in this report should allow more tailored approaches that chime with the government's aim to personalise support.

Employment policy

The first key area of policy we address is employment. As we have consistently highlighted, and in line with national data, our research participants experienced significant barriers in accessing the labour market. Even when asked generic questions about working, respondents often mentioned discrimination. Our first recommendations therefore strengthen policies in the labour market to reduce racial discrimination, rolling out good practices so that parents and carers have better options in the labour market.

Recommendation 1. Data on ethnicity should be better collected among employers, including in the hiring, progression, disciplinary and redundancy processes, and should be segmented by seniority and wages.

Recommendation 2. Employers should adopt various policies to improve the representation of ethnic minorities in hiring and progression. Among those already known to work are:

- including at least one ethnic minority on interview panels – if this is not possible internally, the employed should consider training external experts to interview for the organisation;
- adopting unconscious bias training;
- making more and better use of positive action.

In addition to discrimination, ethnic minorities also clearly experience low wages and high rates of unemployment, creating significant barriers for people to work and care. In addition to better work and higher incomes, another key policy reform would address more flexible working, perhaps by strengthening the right to ask for flexible working, and by government monitoring of how far employers actually offer flexibility when employees request it.

Recommendation 3. Employers should support more flexible working. Policy-makers should consider how they can better support flexibility, especially for carers, including by monitoring how far employers actually offer flexibility when employees request it. There is also a case for considering sabbaticals and longer leave policies, even if unpaid.

A final key labour market barrier for many ethnic minority men and especially women is English language competence. This also affects knowledge and awareness of childcare, caring and disability benefits, so more ESOL funding would clearly not only increase ethnic minority labour market participation but also allow them better to balance work and care.

Recommendation 4. There should be more ESOL funding to improve employability among the tens of thousands of men and women who would like to get work and improve their English, but presently have limited opportunities to do so, including through (but not limited to) Universal Credit.

Childcare: improving access

Our findings have suggested serious barriers for black and minority ethnic families in understanding and using formal childcare or early education. Prominent among these concerns is affordability, with 27 per cent of average family income spent on childcare in the UK. We did not test whether ethnic minorities have particular preferences in terms of how childcare is made more affordable (see EHRC, 2010), so instead we focus on other ways of improving access to formal childcare services.

First and perhaps least controversial is that the government, local authorities and health services need to do more to explain childcare options to parents, especially ethnic minority parents. This is particularly important given our finding that a minority of Pakistani parents and almost no Somali parents were aware of free childcare for 3- and 4-year-olds, and so will be

equally unlikely to know about the extension to 2-year-olds that most of them would be entitled to. Over the course of a year, these 15 hours per week could add up to 2600 hours of work (7800 over 3 years), or indeed a similar amount of hours getting further training or education (including ESOL courses).

Recommendation 5. Better information is needed on childcare options. Too many ethnic minority parents are not aware of free provision in particular, and there should be a push by local authorities and perhaps health providers to inform parents of the 15 free hours of early education for 2- to 4-year-olds.

There is of course a serious question about how far parents would take up free childcare even if they knew about it. This is not so much an issue for Caribbean people in the UK, but appears most prominent among Bangladeshis. Interestingly, while many of our Pakistani and Somali respondents would not take up formal childcare for various reasons – including concerns about food and cultural values – this was often in a context where they were thinking about primary or full-time childcare. Many more respondents suggested they would use formal childcare for at least a few hours a week, and so the lack of uptake of current government commitment to free provision is a lost opportunity. Government policy has framed childcare as 'early education' for a number of years now, but that message has not fully reached ethnic minorities. Given that our respondents were happy to use after-school childcare, promoting the educational, cognitive and behavioural benefits of childcare and calling it 'education' is likely to improve uptake.

Recommendation 6. The cognitive and behavioural benefits of childcare should be better promoted. Ethnic minority parents highly value education, and would perhaps be more likely to take up childcare if they were more explicitly told that it is 'early education', and if they had better knowledge of its benefits.

One obvious policy to increase childcare use and open up further labour market opportunities would be to train more Pakistani and Somali childminders. This would not only improve uptake of childcare among these groups but also increase employment rates. Not all groups prefer to 'match' their carer's ethnicity or religion to their children, but concerns about culturally appropriate care were fairly common among our participants, and probably also apply to Bangladeshis, other black African and indeed white minority groups as well (compare provision of French nurseries in London). This would also, of course, have the effect of increasing the supply of childcare, which is particularly necessary in London.

Recommendation 7. More ethnic minority women should be trained as childminders. With more ESOL funding this training could be much expedited, and councils could consider allowing those with more limited English to care for children if parents agreed, where those parents do not speak English themselves, and where the childminders have completed a certain level of training.

Another key issue for ethnic minority parents taking up childcare is their unsociable work hours. Not only is there a lack of flexible working, but ethnic minorities are also more likely to work evenings, nights and weekends. It is

obviously not easy to stimulate the supply of sessional childcare, but this should be considered by the government and researchers so that ethnic minority parents can better balance work and care.

Recommendation 8. Further research and practice is needed on improving the supply of childcare generally, and for sessional or irregular childcare hours in particular. This is particularly relevant for ethnic minority groups who often work irregular, night or weekend hours (e.g. in restaurants or hotels or as taxi drivers).

Caring for disabled children

Our interviewees confirmed other evidence that black and minority ethnic parents are less likely to take up various disability-related benefits, or to seek support from carers outside the family or in the home. Our recommendations in this section focus on disabled families with children, although we also discuss wider policy changes that affect disabled people generally.

Research has shown that childcare costs are five times higher for disabled children. The current threshold on Working Tax Credit does not reflect this additional cost, resulting in families being worse off (Daycare Trust, 2012a). This suggests that our recommendations on childcare above will be particular pressing among black and minority ethnic families with disabled children, who are already more likely to be living in poverty.

Changes to disability benefits (particularly the Personal Independent Payment and the new Work Capability Assessment) and entitlements again raise the issue of understanding and uptake of benefits. Government research (Jones and Tracy, 2010) shows that black and minority ethnic people are less aware of disability benefits and take longer to access them as a result of lack of knowledge and familiarity, as well as language and cultural barriers. The reform of DLA to the Personal Independent Payment and the eligibility assessment system may provide additional barriers to people unsure of their entitlements. As the Disability Alliance put it: 'From our work with ethnic minority communities and our analysis of a considerable body of research ... we are in no doubt that ethnic minority claimants experience greater problems than the majority of the community in accessing the benefit system.' (Wayne, 2003)

This relates to an issue we have already addressed, namely that some parents felt that their children were less likely to get appropriate diagnoses from statutory services, particularly for children with special educational needs. We suspect that this may be a sensitive issue, given that some ethnic minority groups – particularly black men – have potentially been overdiagnosed for mental health needs.

Recommendation 9. Special Educational Needs Assessments should be checked to ensure they are adequately assessing and addressing needs in ethnic minority families. This will require further engagement with ethnic minority parents, and at times include a translator.

A final and sensitive point we address is the issue of stigma or shame. We have not found much evidence of shame or stigma among black and minority ethnic families with disabled children themselves, although we have found a minority of cases where a wider community may not understand disability,

and a few examples where that misunderstanding can be harmful for adequate care for disabled people and their carers too.

The question of how far society includes disabled people and reduces stigma towards them is an issue that affects all disabled people in the UK, regardless of ethnicity. We anticipate that any work done to reduce the stigmatisation of disabled people generally will have effects on ethnic minorities in the UK. However, we also recognise that there may be a need for greater awareness and support among ethnic minority communities specifically.

Recommendation 10. Public bodies and other relevant institutions (including employers and schools) should do more to combat discrimination and stigmatisation on grounds of disability. There is a need for sensitive work in some ethnic minority communities to raise awareness about disability, and also for targeted support to parents with disabled children where their social networks are less supportive.

Ethnic minority carers and caring policy

Two policy agendas inform our recommendations on caring: the various policies supporting carers themselves and the personalisation agenda.

Carer's Allowance is the main benefit for carers and, as with other benefits, we suspect ethnic minorities are likely less likely to understand and receive this benefit. A full Carer's Allowance equates to only £1.71 per hour for 35 hours of caring per week: many carers report difficulties paying utility bills or mortgages, and half get into debt as a result of caring. These experiences may be even more common among black and minority ethnic carers, given their lower incomes and higher unemployment rates.[14] Another important question is whether ethnic minorities meet all six conditions required to receive Carer's Allowance (see Chapter 6). We anticipate that many ethnic minority older people may not be receiving qualifying disability benefits, not only harming their own levels of support and well-being but also preventing their carer from being entitled to Carer's Allowance.

Recommendation 11. Ethnic minorities need greater awareness and knowledge of Carer's Allowance, as it is not well understood generally, and is likely to have poor uptake among those ethnic minorities entitled to it. There should also be further work to ensure older ethnic minority people are receiving any qualifying disability benefits to which they are entitled.

In addition to Carer's Allowance, another important lever for improving labour market outcomes among carers is employment policy, and in particular flexible working. We have already recommended an expansion of flexible working, but for carers there may be additional policies employers could and should adopt, including flexible leave during times of intensive caring, and perhaps even more creative use of sabbaticals.

A second key policy agenda concerns personalisation. 'Personalisation' is the idea that individuals should manage their own budgets to give them more control over their care, and might be particularly advantageous for black and minority ethnic people with different caring preferences or expectations. Conversely, research suggests that older black and minority ethnic people receive poorer treatment from care services and are less likely to use them. Barriers include a lack of information, language difficulties, differing explanations of how services can support people and stereotyped

assumptions from professionals (Moriarty, 2008). These barriers are likely to become more significant as the ethnic minority population grows and lives in more diverse areas, meaning that councils and other institutions will need to adapt their services in response to this changing demand (Khan, 2011).

Here, the issue of ethnic matching may be relevant both for caring in the home ('domiciliary' care) and in care homes. In terms of support in the home, we suggest below how the personalisation agenda might be better developed to benefit ethnic minority people in the UK.

Runnymede's previous research has considered whether black and minority ethnic older people seek food and cultural options in care homes, and even whether they would prefer to live in homes with more ethnic minority residents (Khan, 2012). We repeat our recommendation in that report here, as we have found evidence that some ethnic minorities may prefer ethnic-specific care homes, while others would prefer more culturally sensitive or appropriate care within universal provision. In the context of this report, if care homes responded better to the needs of ethnic minority older people, their children might feel more comfortable about them living there; this would have the effect of increasing such children's labour market participation.

Recommendation 12. Care homes should provide care that better caters to the needs of ethnic minorities. This could include ethnic-specific care homes, more diverse meal choices (at least on a weekly basis), more training of care workers, more diverse television and cultural offerings, or partnering with local restaurants to provide low-cost meals to particular ethnic minority communities.

As with our recommendations on childminders, we also recommend further training and support for black and minority ethnic carers. This is a somewhat difficult area, however, given that care workers have low salaries and often relatively poor opportunities for progression. Yet given the very high unemployment rate among black and minority ethnic young people, rising to 50 per cent for young black men, combined with the fact that care demand is only going to increase but current migration policy means that the supply of migrant care workers will fall, there is a clear opportunity here for some black and minority ethnic workers. One way of thinking about encouraging black and minority ethnic carers is to consider the other skills and experience they could develop, for example learning Mandarin, Hindi or Portuguese, or developing sophisticated interpersonal skills – experiences that could potentially benefit them in the wider labour market.

The living wage is just one of many important actions that could improve wages in the care sector and other low-paid sectors, as indicated in JRF's anti-poverty employer work.[15] Further recommendations include more rights for agency workers and more affordable childcare (Goulden, 2010). In addition, employers need to be much more responsive and creative in offering opportunities for low-paid workers, particularly ethnic minority workers (Hudson and Netto, 2013). Previous research has also suggested that one way to increase wages in the care sector would be to increase the number of men in the profession and reduce gender inequalities (Himmelweit and Land, 2007). This research also recommended increased wages for carers generally, and reducing working hours for men so that they could take up more caring responsibilities (see also Williams, 2013), recommendations that may also respond directly to the higher unemployment rates for young men, especially young black men.

Recommendation 13. Ethnic minority young people should be targeted for training to gain the skills to be carers, including foreign language skills. Given the low wages and poor progression routes in caring professions, and the already high concentration of ethnic minorities in these kinds of job, the focus should be on skills that are transferable to other jobs, such as foreign languages or 'soft' interpersonal skills, which are valued by a range of employers.

Personalisation applies to more than care homes and the training of caregivers. The Care and Support White Paper sets out wide-ranging reforms for care provision and delivery, defining the key aim of the care system as promoting individual well-being. As Trotter points out:

> This signals a closer alignment with the ideas of care personalisation, and can be seen as a considerable success for the Independent Living Movement. Yet ... the principles of personalisation and individual well-being are delivered in a far narrower way than intended, with a predictable focus on economic factors like personal budgets and direct payments rather than the overall care package ... For [black and minority ethnic] disabled people in particular, this emphasis on direct payments represents a dramatic and potentially disrupting shift. For direct payments to work for users there must be high availability of information, advice and support, exactly the things that recent Scope and ENC research found was lacking. The practicalities of managing payments also assume a day-to-day level of financial capability that many [black and minority ethnic] families simply don't yet possess. Runnymede research has shown consistently that ethnic minority communities typically have worse access to financial services, and less of the kind of support or advice which would enable them to adjust to the direct payments system (Trotter, 2012b).

The current government views the provision of social care in terms of markets, with 'care consumers' expected to 'purchase' appropriate care. Yet 'care markets' are not yet fully developed, a concern the government has recognised with the Department of Health's launch of the Developing Care Markets for Quality and Choice initiative. While this programme emphasises that local authorities should help construct a diverse and fully adequate market for care services, there is no mention of ethnic minorities specifically.

Yet the evidence is that small, community-led organisations are the most effective in supporting ethnic minority disabled people, and that these organisations are struggling at a time of cuts to budgets. They are also unlikely to be able to enter into markets without some support, and unlikely therefore to be among local authorities' 'preferred provider lists'. One possible source of optimism is new solutions that are also being developed in other areas of public service reform, aimed at giving greater control and being more responsive to citizens. Trotter has described this as follows:

> Co-design and co-commissioning of services, which give disabled communities meaningful influence over the service provision, opening up local care markets, might allow small community-led providers to emerge. Removing preferred provider lists, providing training and support to new businesses and improving oversight of competition would make it easier for ethnic minorities. Innovation is also key to successful and efficient service delivery; brokerage services, like Activities Unlimited in Suffolk, provide service users with better

> information, advice and support, while also bringing them together to use collective purchasing power to add leverage for smaller players in local markets ... Utilising such models and combining them with a sustained programme of outreach into [black and minority ethnic] communities could yield the positive results the government is after for the market, and action at the individual, community and systemic levels will be vital if [black and minority ethnic] 'care consumers' are to benefit fully from the changes (Trotter, 2012b).

Recommendation 14. For personalisation to be a reality, and for care markets to function effectively, more innovative solutions are needed. In particular, smaller community-led providers should be encouraged to work together, perhaps under brokerage services, so that people receive appropriate and personalised services, and so that the supply side of care markets is sufficiently developed. One key set of institutions local authorities should consider supporting in this way is those community organisations with the best track record of supporting ethnic minority older and disabled people.

Making policies fair for all

Some policy changes, particularly in the benefits system, seem more likely to disadvantage ethnic minority families, making it harder rather than easier to balance work and care. This is because ethnic minority households are more likely to have particular characteristics that will result in their being worse off under the benefit reforms.

Some policy changes, particularly in the benefits system, seem more likely to disadvantage ethnic minority families, making it harder rather than easier to balance work and care.

For example, poor Caribbean families receive little income from earnings (being more likely to be unemployed), while even those Pakistani and Bangladeshi households not in poverty receive a higher share of income via benefits and tax credits, 'indicating the role of these income sources in helping families avoid poverty' (Platt 2009a). These differences in how benefits, tax and household type affect different ethnic minority groups should inform the government's changes in benefits policy and in terms of child poverty. We are not convinced that the government is sufficiently attuned to these differences and their effect on policy.

Consider the government's new approach to child poverty. Child poverty affects the uptake of childcare, with the most vulnerable families – those that could possibly benefit most from high-quality childcare services – being the least likely to use childcare. The lower the household income, the lower the uptake of both formal and informal care: around half of families (52 per cent) with an annual income of £45,000 or more had recently used formal childcare, compared with 33 per cent of families with a yearly income below £10,000 (Platt, 2009b).

For ethnic minority families with the highest rates of child poverty, some of the government's new proposed explanations are unrelated to the evidence on why ethnic inequalities persist (for example, few Pakistanis have 'generations' of worklessness or experience alcohol addiction or family breakdown), and particularly ignore discrimination. Even those factors that do correlate with child poverty have different effects for ethnic minority groups: 36 per cent of white children in single-parent families are in poverty, while the figure is 46 per cent for black African children in such families (Platt, 2009a).[16] Given the already large gap between ethnic minority and white British rates of child poverty, any change in the measurement of child

poverty and any resultant policy changes must demonstrate they do not increase these gaps further.

In the context of ethnic minority labour market disadvantage, the move to Universal Credit is particularly relevant. Under Universal Credit all work-related benefits will be combined, along with housing benefit, and be paid monthly into a single household account.[17] Because of their lower incomes, higher unemployment and experience of discrimination in the labour market, any policy changes seeking to improve work incentives or changes to welfare will have a great impact on ethnic minorities: positively if the policy works, and negatively if it does not fulfil its aims.

For example, in Bangladeshi and Pakistani households in poverty, a male earner may be receiving tax credits to top up his low income, while women in these households are much more likely to be inactive, and so not presently claiming any (work-related) benefit. Many of these women will never have worked previously and are more likely to speak poor English. For ethnic minority households with one earner, incidences of poverty are still high, so we appreciate the importance of not only increasing male earnings but also improving labour market activity for ethnic minority women.

As we have indicated, Pakistani and Somali women are much more likely to be caring, with some mothers preferring to look after their own children and live below the official poverty line than to use formal childcare. Work conditionality in these groups will either lead to their taking up childcare they do not like or – perhaps a more likely scenario – dropping out of the benefits regime entirely, further lowering their household income. Furthermore, even if these women seek work, many speak poor English, have limited experience in the labour market or may have not worked for a decade or more, while employers often hold discriminatory assumptions about ethnic minority women (see APPG, 2013). It is difficult to imagine that employers will view these women favourably compared to the large number of other people seeking work.

We would like to see more targeted work in and with these communities to help ethnic minority women, especially those who have never worked, better understand the UK labour market. At a minimum, however, there must be increased funding for ESOL, including courses delivered within Universal Credit (see **Recommendation 4**).

For Caribbean families, there is less concern about the uptake of formal childcare, or of course English language skills, although the higher prevalence of single parents means that they are more likely to be disadvantaged by Universal Credit. The government has stated that around 100,000 more people will be in poverty as a result of Universal Credit, and lone parents are disproportionately represented within this population. Gingerbread (2013) has estimated that 200,000 more single parents will lose out than will win under Universal Credit.

Given the higher prevalence of single-parent households among both Caribbean and Somali families, these changes will clearly have a greater impact on those groups, especially considering that both groups are more likely to have larger families, and Somalis appear to have their first child at a younger age. This is especially relevant given the Gingerbread (2013) findings that 240,000 single parents under 25 'may lose £780 per year as a result of poorly-publicised reductions in the level of their personal allowances under Universal Credit'.

Finally, it is worth highlighting that, with respect to Universal Credit, childcare is envisioned as an additional element. According to the charity 4Children, reductions in working tax credits may result in parents with two children in childcare losing £1,560, while the freezing of child benefit for

three years from 2011 will obviously disproportionately affect poorer families and those with larger families (Family and Parenting Institute, 2010). In a context where ethnic minority groups are less likely to be aware of government policies and public services, we are particularly concerned that these changes will disadvantage the groups interviewed in this research, and ethnic minorities generally.

Recommendation 15. The government should rethink Universal Credit in various ways so as not to worsen outcomes for ethnic minorities and other disadvantaged groups.

- The government should reconsider its payment of Universal Credit to households only, and instead transfer at least a portion (say 25 per cent) of the non-housing element to every adult household member. In most cases, payment will be to the male head of household, undermining women's independence and financial inclusion, and reducing their capacity to escape domestic violence. Ethnic minority women are particularly vulnerable to these changes, while international evidence indicates that mothers are more likely than fathers to spend money on children, suggesting that the already high child poverty rates among ethnic minorities may rise further still.
- The government must monitor the effects of Universal Credit by ethnicity. In particular, it must monitor how many ethnic minority women move from economic inactivity into work, and how many families drop out of the welfare system entirely.
- The government should introduce changes to ensure that Universal Credit does not disadvantage and make it harder to balance care and work for single-parent families. Two possibilities are increased childcare support for such families, and greater work incentives under Universal Credit.
- The impact of benefit changes needs to be better explained to groups who are less likely to take up benefits to which they are entitled, and less likely to be aware of upcoming changes. This includes a communications plan for ethnic minorities, targeting community centres, churches, mosques, ethnic and local media, as well as GPs.

Our research findings that many ethnic minorities are more likely to use informal childcare have implications for another key government policy, namely the benefit cap. We know from DWP that 40 per cent of those families affected by the benefit cap will be ethnic minorities. In addition to benefit caps and housing benefit changes reducing people's income, they are also already making people move, especially out of London. This will obviously affect their access to childcare, most notably by reducing their access to family members who provide 'informal' care.

Another key change is that lone parents will be expected to find work when their children are 5 years old, compared to 7 years old at present. This again is more likely to affect ethnic minority families (including Black Caribbean and Somali families) who have higher rates of single-parent households, and those families where cultural preferences mean that mothers may not return to the labour market until children are older (including Somali and Pakistani families).

Finally, since 2010 there have been changes to the childcare element of Working Tax Credit. As Universal Credit rolls out, these will be adopted within that policy as a monthly limit, but the key points are that from 2011 parents had to work more hours (24 vs. 16 previously) to be eligible for tax

credit, while the amount that parents could claim also reduced (from 80 per cent to 70 per cent of their childcare costs). Given the labour market disadvantages we have outlined and the higher costs of childcare for people living in London, as well as the already lower uptake of benefits, this obviously affects ethnic minorities disproportionately.

Recommendation 16. The government should consider further and aim to counteract how changes in benefit policies – particularly the benefit cap and changes in how childcare is supported under Universal Credit – will affect childcare among ethnic minorities. For example, DWP has suggested that 40 per cent of those affected by the benefit cap will be ethnic minorities, which may encourage them to move away from family members who currently provide childcare support and allow parents to work (or to work more hours). This should involve showing data not only on the effects on ethnic minorities but also on how existing policy might counteract these effects and address ethnic inequalities in Britain.

Conclusion

Many policies to improve ethnic minority choices in terms of balancing work and care are universal measures that would benefit all carers in the UK. Two clear examples are more flexible working and more affordable childcare, both of which would particularly benefit ethnic minorities, given their labour market experiences and higher poverty rates. Our recommendations have also highlighted the specific experiences of ethnic minority people, and why and how policy should also respond in a more sensitive and ultimately effective way to ethnic minority disadvantage. The alternative is that ethnic inequalities could worsen.

Our recommendations have therefore focused on how to improve policies where we are more certain of their consequences for race equality and where our discussions with research participants were most significant. Although we believe our recommendations would expand choices and improve lives for ethnic minority people in the UK, we have also sought to reflect people's values and beliefs. Policy-makers must do more to reduce ethnic inequalities in the UK and, as behavioural economics teaches us, that involves working with the grain of people's beliefs, preferences and actions. Our recommendations are based on our understanding of our participants' values and preferences, and so would enable better work outcomes for ethnic minorities in Britain, while also supporting carers and those they care for.

NOTES

1 See http://www.runnymedetrust.org/projects-and-publications/projects/alias-6.html.

2 See http://www.romansrevealed.com/.

3 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231415.

4 The greater proportion living in London also partly explains why DWP estimates that 40 per cent of those affected by the benefit cap will be ethnic minorities.

5 http://www.poverty.org.uk/06/index.shtml.

6 http://www.londonspovertyprofile.org.uk/indicators/topics/work-and-worklessness/worklessness-by-gender-and-country-of-birth/.

7 http://thinkprogress.org/economy/2013/08/08/2435491/being-unemployed-for-over-nine-months-is-the-same-as-losing-four-years-of-experience/.

8 On migrants in the labour market generally, see http://www.ippr.org/images/media/files/publication/2011/05/britains_migrants_1598.pdf.

9 http://www.communities.gov.uk/documents/communities/doc/1202162.doc; see also Harris, 2004.

10 See a Bristol report estimating an average of 3.9 children in Somali families, and that growth only began after 2001/02: http://www.bristol.gov.uk/sites/default/files/documents/council_and_democracy/statistics_and_census_ininformati/2011%20Somali%20Community%20Profile_270212.pdf.

11 http://www.grandparentsplus.co.uk/reports-and-publications.

12 http://www.un.org/en/documents/udhr/.

13 http://www.carersuk.org/newsroom/stats-and-facts. See also http://www.leftfootforward.org/2012/11/where-is-the-coverage-of-carers-rights-day/.

14 We are aware of the 'caring strategy for England' and agree with its main objectives; indeed, we hope our research contributes to their achievement. There are serious questions, however, regarding how far policy has ensured that carers are able to realise these lofty aims, especially black and minority ethnic and other carers at risk of poverty.

15 http://www.jrf.org.uk/blog/2013/11/living-wage-step-toward-anti-poverty-employer.

16 http://www.runnymedetrust.org/news/460/272/Measuring-Child-Poverty-Consultation.html.

17 Universal Credit will replace and merge Income Support, Income-based Jobseekers' Allowance, Housing Benefit, Child Tax Credit and Working Tax Credit.

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http://www.guardian.co.uk/education/2012/may/22/parents-top-up-fees-nursery-mps

http://www.guardian.co.uk/education/2012/feb/03/free-nursery-places-children-education.

http://www.guardian.co.uk/commentisfree/2011/aug/07/social-mobility-invest-parents-babies

Useful links

http://www.ons.gov.uk/ons/dcp171778_251357.pdf

http://www.parentsforinclusion.org/pressrel.htm

http://www.earlyyearschildcare.org/childcare_for_black_and_minority_ethnic_communities.pdf

http://www.london.gov.uk/sites/default/files/DMAG%20Update%2004-2010%20R2008%20London%20Plan%20Ethnic%20Group%20Population%20Projections.pdf

APPENDIX 1

Characteristics of participants in qualitative interviews on caring for older people

Participant ID	Ethnic group	Care provided: if so, for whom and by whom	Formal services received	Employment status
CROO1	Caribbean English participant	Cares for his wife who has ME	None	Is able to work from home
CROO2	Caribbean English participant	Cares for children but provides extra care for son with learning difficulties; also cares for her father who is partially deaf and lives in another house	Pays for formal private care for son	Works flexible hours for the council
CROO3	Caribbean English participant	Receives sporadic care from daughter and neighbour when feeling unwell	None	Retired
CROO4	Caribbean English participant	Lives in sheltered accommodation	Lives in sheltered accommodation: someone cleans for her and provides her medication	Retired
CROO5	Caribbean English participant	Cares for niece every two weeks	None	Painter and decorator
PK001	Pakistani English participant	Provides emotional help to his family; daughter-in-laws cooks and cares for his wife	None	No information
PK002	Pakistani English participant	Cares for mother	Only medical services (GP)	Supply teacher
PK003	Pakistani English participant	Cares for son with bipolar disorder	No formal services	Husband is consultant engineer
PK004	Pakistani English participant	Daughter-in-law provides care for his wife who has high cholesterol	Only medical services (GP)	Accountant
PK005	Pakistani English participant	Daughter-in-law (practical care) and children provide care	Only medical services (GP)	Used to own a post office
AF003	Somalian English participant	Cares for his wife and children, one son suffers from depression – provides his medication	Only medical services (GP)	Owns a greengrocer's shop
AF004	Somalian English participant	Wife and daughter look after him as he has angina and provide him with language support	Only medical services (GP)	No information
WAF003	Somalian Welsh participant	Cares for grandchildren		No information
WAF005	Somalian Welsh participant	Cares for daughter and mother		No information

APPENDIX 2

Carers' profiles by ethnic group (%)

	White British (*N*=1494)	Black and minority ethnic (*N*=115)
Gender		
Male	599	48
% within ethnic group	40	42
Female	895	67
% within ethnic group	60	58
Total	1494	115
Age $X^2(2, N=1609) = 19.36, p<.001$		
45–64	910	46
% within ethnic group	61	40
65+	584	69
% within ethnic group	39	60
Total	1494	115
Marital status		
Single/never married	98	4
% within ethnic group	7	4
Married/partnership	1180	85
% within ethnic group	79	74
Divorced/separated	134	17
% within ethnic group	9	15
Widowed	82	9
% within ethnic group	6	8
Total	1494	115
Working status $X^2(2, N=1609) = 83.40, p<.001$		
Male	599	48
% within ethnic group	40	42
Female	895	67
% within ethnic group	60	58
Total	1494	115

ACKNOWLEDGEMENTS

This report involved a great deal of collaborative working during the data collection, interpretation and write-up phases of the research. The Runnymede Trust and Brunel University built on previous research funded by the Nationwide Foundation, the Leverhulme Trust and the National Institute for Social Care and Health Research. Ethnic Focus recruited and interviewed the parents in this study, with Dalveer Kaur assisting with the interpretation of these interviews and the literature review. Professor Vanessa Burholt provided further advice on our findings, and Dalia Ben-Galim generously read and provided comments on the final draft, much improving our policy recommendations. We are indebted to the Joseph Rowntree Foundation for their support throughout this process, especially that of Helen Barnard, our research manager. Finally, we are particularly grateful for the time and energy of our research participants and those who helped us recruit and engage with them, especially given the challenges of balancing the already onerous demands of work and care.

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The Joseph Rowntree Foundation has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the authors and not necessarily those of JRF.

A CIP catalogue record for this report is available from the British Library.

First published 2014 by the Joseph Rowntree Foundation
ISBN: 978 1 90958 617 8 (pdf)
Project managed and typeset by Cambridge Publishing Management Limited

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York YO30 6WP
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