Equality and Human Rights Commission

Research Report

Low-paid ethnic minority workers in health and social care during COVID-19: A rapid review

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Executive summary

This report was commissioned by the Equality and Human Rights Commission to support a statutory inquiry under Section 16 and Schedule 2 of the Equality Act 2006 looking into the treatment of ethnic minority workers in low-paid roles (which may also be insecure and precarious) prior to and during the coronavirus (COVID-19) pandemic.

There are long-standing concerns of inequalities in the workplace among ethnic minority workers in the health and social care sectors in Britain. Understanding the barriers and constraints to positive work outcomes for ethnic minority workers is essential to design evidence-based policy recommendations and interventions to ensure equality in the workplace and beyond. The Equality and Human Rights Commission (EHRC) inquiry into racial inequality in health and social care workplaces aims to gather timely evidence to formulate policy and practice recommendations to enhance outcomes for ethnic minority low-paid workers. This rapid review forms one part of the evidence base. The review aims to gather existing evidence on the work experiences and outcomes of ethnic minority workers in health and adult social care (ASC) across England, Scotland and Wales. In particular, it focuses on those that are low paid.

The analysis presented in this report is based on a rapid review of evidence, since 2017, from the UK and Britain, with attempts to separate findings related to England, Wales and Scotland. However, the majority of the identified literature reported on experiences from the UK as a whole, or more specifically in England. There was only one specific to Scotland and one focused on Wales. Publications used a variety of methods; including qualitative approaches, surveys, analysis of existing data or a mixture of methods.

This report covers both the health and adult social care sectors in Britain. However, the two sectors have some distinctive features that have implications for the workforce's structure, arrangements, and the delivery of health and care services. These differences are noted and taken into account in the analysis and interpretations of results.

Key Findings

The review identifies the significant contribution of ethnic minority workers to both the health and adult social care sectors across Britain. However, it also presents the substantial negative experience of ethnic minority workers across a range of workplace indicators and outcomes. Ethnic minority workers are concentrated in low-paid jobs and under-represented in senior management roles and higher pay bands in both sectors. Furthermore, ethnic minority workers are more represented among private social care providers, where insecure contracts, fragmented work and lower pay rates are more evident.

There are differences in how ethnic minority workers are recruited into both health and ASC in Britain, with recruitment agencies being an important source of recruitment. There is also evidence of recruitment processes favouring White British workers, even in the most diverse regions and cities such as in London. These differences are most evident when workers have multiple identities where ethnicity, gender and religion interact. The findings suggest that ethnic minority workers make considerable efforts to conform and accommodate biases at all employment stages, including at the recruitment stages.

The review analysed findings specific to workplace experiences. It highlighted exposure to harassment and bullying in the workplace and lack of in-work support from line managers and colleagues among ethnic minority workers in health and ASC across various roles and pay grades. Furthermore, ethnic minority ASC workers were significantly more likely to be subject to overt and covert racist behaviour from service users than White British workers. The literature identified managerial and co-workers' support as important moderators to stress and burnout at work. The review shows that ethnic minority workers have significantly reduced levels of such support in the workplace with adverse implications for their health and wellbeing.

Ethnic minority workers in health and ASC are shown to have less favourable work outcomes concerning pay and rewards, career progression, and job satisfaction and stress. Pay gaps are particularly evident in the health sector, primarily due to the general low level of pay in ASC. However, ethnic minority workers were under-represented in managerial and supervisory roles in both sectors.

The coronavirus (COVID-19) pandemic has taken a significant toll on the health and social care workforce; however, this effect was much more pronounced in ethnic minority workers. Ethnic minority health and social care workers had higher rates of both COVID-19 infections and related deaths. Some research linked these differentials in outcomes to the less empowered position of ethnic minority workers in the sector, their concentration in specific occupations within the sector that involve higher degrees of risk, institutional racism, and wider socio-demographic and economic inequalities.

Evidence found in the review identified present and past structural racism as key explanatory factors for the observed ethnic inequalities in health and social care work outcomes. Although there has been some progress in developing policies specific to employment race equalities in Britain, these national-level policies fail to address everyday racism and embedded preconceptions and biases within the workplace. Ethnic minority workers reported a lack of trust in health and social care employers dealing with racism and providing fair and equal work environments. Some of the manifestations of institutional racism appeared in the existence of power hierarchies that favour White British males and reduce ethnic minority workers' career progression opportunities.

Interventions to reduce ethnic inequalities

The review identified strategies and interventions that are likely to reduce ethnic inequalities in workforce outcomes from the recruitment process to pay and career progression and the workplace experience. The most promising interventions related to creating adequate social networks and a community of practice within the workplace that allows ethnic minority workers to receive much-needed support. Other interventions, such as anti-bullying and equality training, received a mixed assessment in the literature.

Some research findings warned of potential further adverse effects of some training programmes on ethnic minority workers. Ensuring a collective voice for ethnic minority workers was perceived as essential to ensure positive change in their experience.

Gaps in the literature

Almost all publications reported on the experience in England, or reporting evidence on Britain as a whole, with three further publications: one covering both Scotland and England, one specific to the Scottish and one to the Welsh experiences. The role of the NHS England Workforce Race Equality Standard (WRES) was evident in creating more detailed information on the experience of ethnic minority healthcare staff over the past several years. While there are some aggregate data on ethnic minority healthcare staff provided by NHS Scotland and Wales, there is no equivalent to the detailed WRES survey data in either Scotland or Wales. Many of the identified publications had a range of research questions that included the experience of ethnic minority health and care workers but not as the core research topic.

Introduction

Understanding the barriers and constraints to positive work outcomes for ethnic minority workers in the health and social care sectors is essential for designing evidence-based policy recommendations and interventions that ensure equality in the workplace and beyond. Low-paid health and care workers are the backbones of these sectors.

The EHRC inquiry into racial inequality in health and social care workplaces aims to gather timely evidence to formulate policy and practice recommendations to enhance outcomes for ethnic minority workers. This rapid review forms one part of such evidence base. It will complement surveys, focus groups and interviews to be conducted by the EHRC with relevant individuals and organisations.

Background

In England and Wales, workers from Black, Asian and Minority Ethnic (ethnic minority) groups and from migrant backgrounds are over represented in low-paid sectors in general (Weekes-Bernard, 2017), and underrepresented in higher paid occupations within sectors, including health and social care low-paid jobs (Skills for Care [SfC], 2020; Workforce Race Equality Standard [WRES], 2019; Social Care Wales, 2021). Similar patterns are observed in Scotland, Meer et al. (2020) indicate that ethnic minority individuals are concentrated in the lowest-paid work. Furthermore, one-third of ethnic minority people report racial discrimination experiences, and a slightly higher proportion considers racial discrimination to be a widespread issue in Scotland (Meer et al., 2020).

There are long-standing concerns of inequalities in the workplace among ethnic minority and migrant workers in the British labour market, including their low-paid work concentration. Recent research (Living Wage Foundation, 2020) suggests that low pay disproportionately affects personal care service occupations, including social care workers, where ethnic minority workers are over-represented (Skills for Care, 2020). While earlier research suggests a reduction in the importance of associating ‘whiteness’ in determining being ‘British’ (Tilley et al., 2004), evidence presented in this review highlights that ethnic minority British individuals continue to suffer from discrimination and institutional racism in the employment sphere.

Furthermore, race interacts with nationality, religion, gender, and other social markers to influence workers' labour market opportunities negatively (Khattab & Hussein, 2018). Such adverse influences span throughout the employment processes, from recruitment to working conditions and progression opportunities. Racism and discrimination at work lead to losses at the labour market level such as deskilling and skill under-utilisation (Rafferty, 2020) and several adverse work and individual, health and wellbeing, outcomes (Ethel & William, 2020; Serafini et al., 2020).

Inequalities explored

Potential determinants of such inequalities are varied and operate at multiple levels and dimensions. These include individual prejudice and structural racism and discrimination and the effects of cumulative disadvantages across the life course of different groups of workers, and potential workers. Other factors include:

- lack of awareness of employment rights
- communication barriers
- differentials in skills
- lack of workplace support, and
- lack of empowerment and 'voice' of ethnic minority workers.

Furthermore, a changeable political and policy landscape may lead to further discrimination, including reports of negative experiences among White European workers in the UK since the Brexit referendum (Rzepnikowska, 2019). However, evidence suggests that the level of discrimination observed among Black African individuals is significantly more systematic and higher than that observed among White migrants in the UK (Heath and Di Stasio, 2020).

The health and social care workforce in England, particularly the latter, includes a significant proportion of workers paid on or below the national living wage (Hussein, 2017a; SfC, 2020), with insecure work contracts that force many to work long hours to maintain regular incomes. Simultaneously, both ethnic minority and migrant workers are over-represented in these sectors, and women make up the vast majority of those paid the lowest wages (SfC, 2020). Thus, many of the workers in low-paid jobs in health and social care are vulnerable to unfavourable working conditions and adverse outcomes that are likely to be linked to the combined effects of race, gender and nationality. These have several adverse implications for the individual workers' wellbeing, employment outcomes, and the quality of care provided (Birks et al., 2017; Etherington et al., 2018; Milner et al., 2020).

Recognising the unfavourable outcomes of ethnic minority workers in England, the National Health Service (NHS) Workforce Standard, known as the Work Race Equality Standard (WRES), was introduced in 2015 to address these specific concerns. The Scottish Government Race Equality Framework share similar aspirations; however, it does not entail collecting detailed data on work outcomes for ethnic minority healthcare workers similar to the WRES. Moreover, no similar initiative exists concerning the experience of ethnic minority or migrant workers in adult social care.

The impact of COVID-19

The COVID-19 pandemic has exacerbated the long-standing workforce challenges in both the health and social care sectors. The pandemic's impact on health and care workers is unprecedented, with both rates of infection and related deaths reportedly much higher among health and social care workers than any other employment sectors (Office for National Statistics [ONS], 2020a). Earlier analysis of death records at the start of the pandemic, from March to April 2020, showed that 6 out of 10 doctors and healthcare workers who died from COVID-19 were from ethnic minority groups (British Medical Association, 2021). The impact on frontline social care workers was significant, with recent reports of considerable increases in workload and feelings of stress, among others. Findings from recent studies (Haque et al., 2020; Warren and Lyonette, 2020) indicate women from ethnic minority backgrounds are twice as likely to work in low-paid, insecure and high-risk jobs and to be classified as key workers. Furthermore, they were the worst affected by COVID-19 and associated measures such as the first national lockdown.

Methodology

Analysis

The analysis presented in this report is based on a rapid review of evidence methodology to collate recent evidence specific to the research questions outlined in appendix 1. The review was informed by guidelines for the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (Moher et al., 2009).

The review started by identifying search terms through an initial scoping of the literature and a specific search to identify definitions. A search strategy protocol was then devised and discussed with key stakeholders and the EHRC and refined (see appendices 1–3 for the protocol and search terms). The searchers for this review used the final protocol and focused on published research, restricted to recent evidence since 2017. Some exceptions were made for seminal and key work prior to 2017.

The review covered Britain and captured evidence specific to England, Scotland and Wales when available. Literature, published in English, was identified and assessed. The findings were summarised thematically.

During the initial search phase, publication titles and abstracts were assessed for relevance before the retrieval of the publications' full text. Evidence was analysed thematically and organised according to the research questions. Data from the literature were analysed and organised into the following sections, which was guided by the research questions of the review:

- the contribution and profile of ethnic minority workers in low-paid work in health and social care
- differentials in the recruitment of ethnic minority workers
- workplace experience of ethnic minority workers:
    - harassment and bullying
    - in-work support
- work-outcomes
    - pay and rewards
    - career progression
    - job satisfaction, stress and burnout
- the impact of COVID-19 on ethnic minority health and social care workers
- evidence of institutional racism and discrimination
    - structural racism and the experience of ethnic minority workers during the pandemic

- common experience across all ethnicities
- interventions to reduce ethnic inequalities in the workplace, and
- gaps in the literature.

Literature coverage

Figure 1 presents the literature search PRISMA flow diagram. Over 4,000 publications were identified through the combined searches detailed in appendix 1. Following removal of duplicates and title screening, the abstracts of 233 records were assessed according to the inclusion/exclusion criteria. Following this assessment process, a total of 84 records were eligible for full-text assessment. The full text was retrieved for 84 records, and 35 were judged to be relevant for inclusion. An additional 16 records were identified through cross-referencing and a network of experts. In total, 51 records were included in this review.

Most of the included records were published in 2020 (n=19); followed by 2017 (n=12); with eight published in 2019; nine in 2018 and only three records prior to 2017 (these were identified as seminal publications specific to the research scope and focus). Most of the records included were peer-reviewed journal articles (n=31) or reports (n=17) with one each of a book chapter, a book and a PhD thesis.

Almost an equal number of publications reported research specific to the health sector (n=16) or adult social care (n=17), which included information on low-paid and ethnic minority workers. A further two publications were specific to public service professionals (including social service workers). Ten records had a wider focus on low-paid work and ethnicity, including, but not primarily, in the health and social care sectors and eight covered the experience since the COVID-19 pandemic with a specific focus on ethnicity and health and social care workers. Almost all publications reported on the experience in England (n=29) of reporting or evidence on Britain as a whole (n=19) with three further publications: one covering both Scotland and England; one specific to the Scottish and one to the Welsh experiences.

The majority of the publications employed quantitative analysis of existing workforce data or household surveys (n=15); eleven studies employed qualitative techniques with a small number of participants (less than 30) and eight with larger groups of participants (more than 30); Seven publications were based on surveys; five were reviews; three employed experimental designs and the last three were commentaries or based on policy analysis.

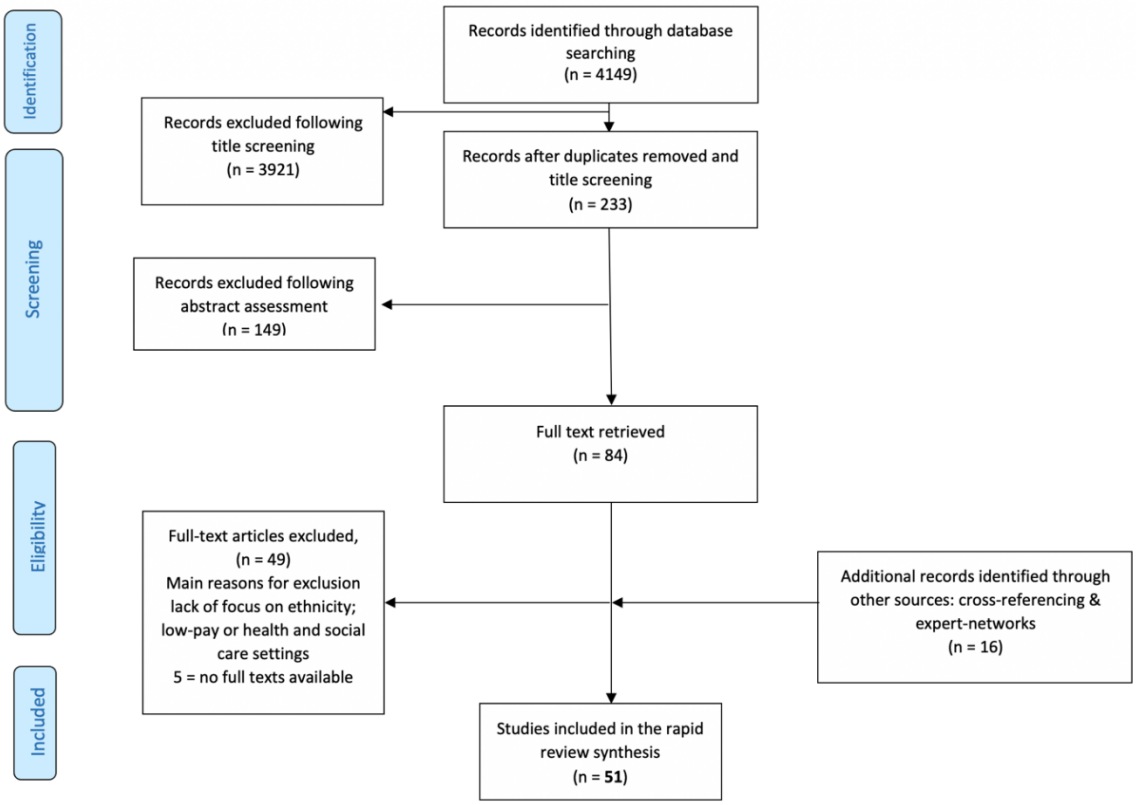

Figure 1: PRISMA flow diagram of literature included in the review

Findings

Contribution and profile of low-paid ethnic minority workers

This report covers both the health and adult social care sectors in Britain. However, the two sectors have some distinctive features that have implications on the structure and arrangements of both the workforce and on how the health and care services are delivered. Health care in Britain is delivered through the NHS, which is universally available to all British residents and is free at the point of delivery in the three nations: England, Scotland and Wales. It is funded in the main through a budget set by the central government. Most of the budget is given directly to NHS England; then distributed to clinical commissioning groups, NHS providers and specialists' services (Royal College of Physicians, 2018).

The responsibility for NHS Scotland is devolved to the Scottish Government to decide the budget then distribute to NHS Boards and Special NHS Boards, which have full responsibilities to plan, commission and deliver health services in Scotland. Similarly, the Welsh Government is allocated a budget from the UK central government (Westminster), which forms a part of the 'block grants' distributed by the Welsh Assembly Government.[1]

[1] NHS Wales, Budget and Charges [Accessed 17 march 2021]

The NHS is the largest employer in Britain; in 2020, this included 1.17 million full-time equivalent (FTE) jobs in England,[2] 143,440 in Scotland,[3] and 85,458 in Wales.[4] It is also one of the largest employers of ethnic minority workers in Britain: almost one in five staff working in England NHS Trusts is from an ethnic minority background, and 10% of its workforce are of Asian ethnicity (Carter, 2018; Kline et al., 2017). However, representation varies across other health arm's length bodies (ALB) from 6.4% in the NHS Business Services Authority to 19.9% in Public Health England (WRES, 2020). These figures are not adjusted for the large proportion of unrecorded staff ethnicity (reaching 13.5% in some organisations).

Ethnic minority workers in the NHS are more concentrated in support roles across England and regionally (15% in England and 51% in London); with London recording the highest ethnic minority workforce representations (Kline et al., 2017). Data collected repeatedly over several years show that ethnic minority workers in NHS England remain significantly less represented among senior grades across all groups of workers (Kline et al., 2017; WRES, 2020). In Scotland, most healthcare professionals where ethnicity is known were White (69.6%) followed by Asian (2.3%).[5]

On the other hand, adult social care (ASC) is both means- and needs-assessed and the delivery of services is the responsibility of local authorities (LAs). Funding for social care is more complex, and ASC services are not free to everyone. People with care needs are required to be assessed by the LAs to identify care needs and funding options. There are some differences in the level of state funding of ASC in Scotland compared with England and Wales. In Scotland, for example, the LA has a duty to provide care at home without charge for people aged over 65 assessed as needing personal care, even if the older person had the means to pay for the service.[6]

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[2] NHS Digital, 2020, 'NHS Workforce Statistics - June 2020' [accessed 17 March 2021]

[3] Turas Data Intelligence, 2020, NHSScotland Workforce data tables' [accessed 17 March 2021]

[4] Stats Wales, 2021, NHS staff by staff group and year [accessed 17 March 2021]

[5] NHS Education for Scotland, 2020, NHSScotland workforce data to June 2020 [accessed 17 March 2021]

[6] The Health Foundaton, 2018, 'Free personal care: what the Scottish approach to social care would cost in England' [accessed 17 March 2021]

It is argued that a progressive agenda of marketisation and personalisation of care has created a quasi-market for care services with a significant role for private suppliers and purchasers (Carter, 2018; Hussein & Christensen, 2017). Unlike health care – which is primarily provided through 'one' provider: the NHS – ASC services across England, Scotland and Wales are provided through a mix of a large number of organisations. In England, there are nearly 20,000 private, not-for-profit and state/Local Authority organisations across 38,000 care-providing locations with a workforce on a bar with that of the NHS at 1.16 million FTE jobs (SfC, 2020).

In Wales, ASC is commissioned to 1,300 providers and employs 53,000 workers; 83% reported their ethnicity as White, 11% preferred not to say and only 5% identified as belonging to an ethnic minority group (Data Cymru, 2019).

Ethnic minority workers form a significant part of the ASC sector in England at 21%; this is more diverse than the overall population of England (14%). Furthermore, 12% of all workers are of Black ethnicity, compared with 3% in the general population (SfC, 2020). London has the most diverse ASC workforce (66%) and the North East the least diverse (3%). Ethnic minority workers in ASC are over-represented in direct care jobs and nursing and under-represented in other professional roles and senior management.

Furthermore, evidence points to the over-representation of ethnic minority and migrant workers in the private sector and in jobs with insecure contracts and agency working, such as live-in and domiciliary care (services supporting an individual in their own home) (Farris, 2020; Hudson et al., 2017; Hussein, 2017b; 2018). Around a quarter of the workforce were recorded as being employed on a zero-hours contract (24%, or 375,000 jobs); with zero-hours contracts more prevalent in the private sector (SfC, 2020).

In Scotland, between 66 and 84% of the 206,400 Scottish social services' workforce reported their ethnicity as White, 2% as ethnic minority and 22% as unknown (Scottish Social Services Council, 2020).

Hussein et al. (2014) used a large national workforce dataset to investigate the specific experience of ethnic minority workers in ASC. They showed British ethnic minority workers were employed significantly more in the private sector and in domiciliary care work, both characterised by insecure contracts, than White British workers after controlling for other factors. While their analyses showed that men are more likely than women to occupy managerial and supervisory roles in ASC, this privilege was not evidenced among men from ethnic minority groups (Hussein et al., 2016).

Differentials in the recruitment of ethnic minority workers

Current evidence highlights differentials in the recruitment process and outcomes of ethnic minority individuals in both the health and ASC sectors.

Shortlisting and profiling

In the NHS, there is considerable evidence of the existence of recruitment processes favouring White applicants, with research indicating that White applicants were 1.57 times more likely to be appointed from shortlisting compared with applicants from an ethnic minority background who have similar qualifications. In 38 English trusts (17%), White staff were more than twice as likely to be appointed from shortlisting compared with Black and Minority Ethnic staff (Kline et al., 2017). These variations were observed even in regions with high levels of diversity in the population group. Kline et al. (2017) indicated that the greatest likelihood of White staff being appointed from shortlisting was in London, despite it having the most diverse population in the UK.

Furthermore, Heath and Di Stasio (2019), employing an experimental design, sent out 3,200 fictional online job applications to advertising employers in England, including those in health and social care sectors, randomly varying the minority background of fictitious job applicants while holding their skills, qualifications and work experience constant. Applications profiling ethnic minority candidates received fewer positive responses than similar applications with White British names (15% vs 24%). Less favourable outcomes were particularly evident among applications portraying individuals from more visible and culturally distinct ethnic minority groups, such as Black African candidates. These differentials held for applications made by applicants who identified their race to belong to regions with large Muslim populations, such as Pakistan, Bangladesh and the Middle East. At the same time, candidates portrayed as from White non-British nationalities such as Western Europe received similar responses to their White British counterparts.

Employment opportunities and institutional discrimination

Hammond et al. (2017) examined equality in employment opportunities among graduate nurses and physiotherapists from ethnic minority backgrounds. Their study acknowledged institutional discrimination in the healthcare workplace, including in nursing. Most of their sample, (13 out of 18), were recruited to nursing or physiotherapist jobs six-months after graduation, which corresponds to national graduate employability figures. However, most participants felt that they needed to do all the preparation themselves rather than seeking support from their higher education institute, as they had seen their fellow White students do. The findings suggest that newly qualified staff from ethnic minority backgrounds have to conform and 'fit in' and make conscious efforts to accommodate existing biases throughout the recruitment process. Hammond and colleagues also highlighted that healthcare organisations do not seem to be making necessary efforts to prepare or adapt to the diversity of the workforce.

Qureshi et al. (2020) examined the recruitment of British Asian male nurses into the NHS and highlighted the negative influences of the interplay between ethnicity and gender. These were portrayed through various forms and drivers, including pre-conceived biases surrounding specific 'qualities' of being a good nurse with adverse implications on the recruitment and work experiences of male ethnic minority nurses. For example, several participants reported feeling discriminated against during both recruitment and promotion processes compared with the experience of individuals with similar experience identifying as White female nurses.

Butt et al. (2019) considered the challenges faced by refugee healthcare professionals when seeking employment in the UK. They used data collected through the Building Bridges Programme from 2009 to 2018. The Building Bridges Programme is a London-based multi-agency collaboration supporting refugee healthcare professionals during their employment process to the NHS. The data covered information related to 595 health professionals from 31 countries, most of whom (n=372) were qualified doctors, but also qualified pharmacists, dentists, biomedical scientists, physiotherapists and nurses in their home countries. Through support from the programme, most participants secured jobs or training in healthcare settings, however, with considerable downward mobility. For example, only 65 refugee doctors were able to secure clinical apprenticeship scheme jobs while 109 doctors were only able to secure jobs in associated healthcare professions such as healthcare assistants, phlebotomists or nursing assistants (Butt et al., 2019).

Individual challenges

The authors identified a number of individual-related, rather than systemic, challenges such as lack of knowledge and information, including those related to language and culture, as well as psychological trauma associated with their migration pathways. They highlighted that many participants found differences in the learning process, such as a greater emphasis on multi-disciplinary interactions, and the use of idioms and cynicism from colleagues and managers within a learning or a professional context, challenging and difficult to navigate.

Recruitment methods

Figgett (2017), based on a study conducted by Skills for Care employing a survey of 140 ASC employers in England, identified a wide range of recruitment methods to social care jobs. Such methods included employee referrals, advertising, as well as advertising in the local press and community. Nearly half of respondents to this survey stated employee referrals and word of mouth to be the most successful recruitment techniques.

The role of employment agencies in recruiting for ASC roles was found to be particularly important, especially for recruiting migrant workers to live-in and home care roles (Farris, 2020). These findings resonate with the experience of the wider ethnic minority populations when seeking employment. For example, Kerr (2018) employing a large survey of 6,506 employees, found that nearly 60% of ethnic minority workers register with employment agencies compared with 46% White British participants. EU-8 migrant workers, in particular, were over-represented in low-paid jobs in different industries, including social care and are often recruited through agencies or gangmasters (Barnard et al., 2018). These variations in the reliance on recruitment agencies among ethnic minority and migrant individuals are linked in the literature to weaker social capital and poor labour market connections in comparison to White British individuals (Figgett, 2017; Howells et al., 2018; Hussein and Christensen, 2017; Sahraoui, 2019).

Challenges by gender

Furthermore, research points to a large gender effect and an interplay with ethnicity when considering working in health and ASC as being 'good jobs for women' (Howells et al., 2018). This may shape choices in relation to job roles and employment patterns and types. For example, such perceptions may facilitate the acceptance of trade-offs between flexibility and career progression opportunity among certain groups of workers including ethnic minority women and migrant workers (Farris, 2020; Howells et al., 2018; Sahraoui, 2019). For women in particular, having other caring responsibilities including school-aged children prioritises the flexibility of working patterns over career progression opportunities and levels of pay (Hudson et al., 2017).

Focusing on migrant men in social care, Hussein and Christensen (2017), highlight how the marketisation of ASC, and the introduction of personal budgets, create 'niche' markets for employing migrant and ethnic minority male care workers into the sector. For example, there is a high number of men with long-term care needs in receipt of personal budgets who look for specific characteristics, including race and gender, when recruiting personal assistants or support workers. The authors argue that while such 'niches' in the labour market create opportunities for migrant and ethnic minority male workers; they simultaneously pose several risks including labour exploitation, under-employment and deskilling, among others.

Self-employment

An understanding of the way choices are affected by various perceptions and views might explain the observed higher prevalence of self-employment among ethnic minority health and ASC workers (Howells et al., 2018; Hussein and Christensen, 2017). Existing cultural biases within employers and organisations could act as drivers for certain employment choices, initiated by the individuals, in an attempt to avoid discrimination and as perceived to enhance their occupational mobility (Howells et al., 2018). Furthermore, financial pressures and the need for income to send to their home country are observed to be important explanatory factors in the decision of migrant workers to accept low-paid jobs even when they hold higher qualifications (Christensen et al., 2017; Sahraoui, 2019).

Mode of recruitment

Earlier research by Hussein and colleagues (2014) shows that employers in ASC reported recruiting significantly higher proportions of White workers from the retail sector than ethnic minority workers. On the other hand, significantly higher proportions of ethnic minority workers were recruited through employment agencies (8% vs 2%, respectively). These findings, based on the analysis of a large workforce dataset resonate with more recent qualitative studies, which have also highlighted that employment agencies vary in the level of support they offer to recruits with considerable variation in the quality of contracts offered through this route compared with being recruited directly by the care providers (Farris, 2020; Sahraoui, 2019).

Workplace experience of ethnic minority workers

The review highlights a range of differentials in the workplace experience of ethnic minority health and social care workers, including those in low-paid jobs compared with their White British counterparts. The findings are organised below under two main themes: harassment and bullying, and in-work support.

Harassment and bullying in the workplace

Harassment and bullying in the workplace can take a variety of forms and can be perpetrated by colleagues, managers, service users and patients or the general public. They can be overt or covert in nature and can be reflected in prejudice and discriminatory behaviour, unconscious bias and microaggression or more verbal and physical harassment.

Analysis of WRES (2016) data indicated that ethnic minority staff across NHS England are significantly more likely to experience discrimination at work from managers and co-workers, while all staff are equally likely to experience harassment or bullying from patients (Kline et al., 2017). However, other studies indicated that ethnic minority healthcare staff, including students in placements, were subjected to higher incidents of bullying and harassment from patients (Birks et al., 2017).

In 2019, the percentage of staff experiencing harassment, bullying or abuse from other staff in last 12 months was significantly higher among ethnic minority staff in NHS English trusts when compared with White staff (29% vs 24%), these figures were higher than those observed in 2018 (WRES, 2020). However, some organisations, such as the NHS England Blood and Transplant (13.9%), reported no difference between White and ethnic minority staff; these organisations were the only ones to see a decline in reported incidents between 2018 and 2019.

In NHS England, ethnic minority staff were more likely to report having personally experienced discrimination at work from a manager, supervisor or co-worker. Within NHS trusts, 15% of ethnic minority staff reported this compared with only 6% among White staff (WRES, 2020). Furthermore, ethnic minority staff in NHS England, across different job roles, are significantly more likely to be disciplined than White staff members (Kline et al., 2017). The relative likelihood of ethnic minority staff entering the formal disciplinary process compared with White staff was 1.24 in 2018 and 1.22 in 2019 (WRES, 2020).

A study focusing on measuring the prevalence of bullying among nursing students in hospital placements in the UK and Australia had a sample of 561 UK participants including 11% of overseas born and 10% ethnic minority students (Birks et al., 2017). There were higher rates of reported bullying among male students in the UK, the reverse was observed in Australia. UK students from Black or African ethnicity, and those for whom English was not their first language, reported the highest level of bullying during their placements. Students identified other nurses as the main perpetrators. Bullying incidents ranged from subtle public humiliation, feelings of injustice and unfair treatment at work to physical (including sexual) harassment.

Learning opportunities

According to Birks et al. (2017), the most common unfair treatment at work was related to being denied learning opportunities and lack of acknowledgement for good work. According to this study, physical violence was perceived to be more prevalent in the form of a threat rather than actual, although a significant minority reported actual physical violence. The study did not find any significant differences in the experience of physical violence according to ethnicity. The authors highlighted the findings related to ethnic minority and non-native English-speaking students in the UK as concerning and might indicate a general higher level of racism and intolerance in the workplace when compared with the Australian experience. This is particularly alarming when situated within a context of high contribution from migrant and ethnic minority workers in the British NHS.

Burnout

Johnson et al. (2019) examined the prevalence of bullying and its relationship with burnout and patient safety among a sample of hospital nurses and midwives in the UK. They found that a significantly higher rate of ethnic minority participants, across all grades, reported experiencing discrimination at work in the previous year compared with White participants (21% vs 8%). The odds of experiencing discrimination were three times higher for ethnic minority participants. They found a significant association between bullying and discrimination and high burnout. Furthermore, using path analysis, they established an indirect link between bullying, discrimination and perception of patient safety via their influence on burnout. They suggested that tackling bullying and discrimination at the organisational level would result in enhanced outcomes for workers and improved patient safety.

Intersecting identities

Certain groups of ethnic minority health and care workers face additional challenges due to overlapping ethnic, race, religion and migration identities. Younis and Jadhav (2020) examined the impact of racialised policies like Prevent on institutional racism in the NHS. They discussed how the introduction of Prevent policy – which seeks to avert individuals from endorsing, joining or becoming terrorists in the future – as a 'duty' on the NHS as a public body, has effectively made health care a 'pre-criminal' space. They employed an ethnographic methodology consisting of policy and document reviews, 17 interviews and observations of Prevent training sessions in London between 2017 and 2019. Their study documented several incidents involving clear racial profiling of Muslim patients as a result of the Prevent policy.

They also documented some incidents impacting directly on Muslim mental health professionals. A particular example was given of a Muslim professional who made a referral for a White non-Muslim patient, who showed tendencies of future violence, to Prevent programme being rejected by senior colleagues. This incident made a clear impression on the professional involved that such policy is geared exclusively to 'particular groups and ideologies' with a potential to exacerbate the levels of discrimination observed among these groups (Younis & Jadhav, 2020; p.619). They concluded that attention is needed to reduce institutional racism within the NHS.

Overt and covert bullying and discrimination

Several studies reported incidents of overt and covert bullying and discrimination from users and patients toward ethnic minority ASC workers as almost normal expectations (Manthorpe et al., 2018; Stevens et al., 2012; Spiliopoulos et al., 2020; Tinarwo, 2017). Manthorpe et al. (2018), in a study focusing on ASC managers' perspectives on workforce diversity, highlight that managers reported that although overt and covert racism from care users towards ethnic minority staff appeared to be less common than in the past, it remained a source of conflict. The latter might relate in particular to the use of, and fluency in, the English language where interactions in between staff and care users are highly dependent on 'sensitive' use of language. They highlight the important role of managers and supervisors in addressing and countering the effects of conflict and distress. The role of in-work support from managers and co-workers is highlighted in other research as crucial in reducing the effect of racism and discrimination in ASC settings. However, recent in-depth research suggests that ethnic minority workers report significantly lower levels of such support (Hussein, 2018).

Spiliopoulos and colleagues (2020), drawing on qualitative interviews with 14 migrant care workers in rural England, discuss how this group experience everyday 'otherness' by the care users and the community. This was particularly the case among individuals identifying themselves as 'dark-skinned' including those from the Philippines. They also explain how participants felt that it was expected from them to 'blend in' and absorb the implications of being 'othered' while maintaining their professional integrity. These experiences occurred in the workplace, from managers, colleagues and service users, as well as from the public.

Furthermore, other research highlights that these experiences were not exclusive to rural locations, with some stereotypes that foster discrimination associated with experiences of discrimination among different groups of workers (Sahraoui, 2019; Stevens et al., 2012). This is observed within different contexts and care settings. For example, care live-in recruitment agencies in London reported service users' preferences for certain groups of workers that matched certain 'colour' or racial characteristics (Farris, 2020).

In-work support

Supportive work environments have been shown to be associated with various positive work outcomes including career progression, organisational commitment, retention and the wellbeing of workers. Several studies identified the lack of support for ethnic minority health and social care workers as a significant concern for workers' wellbeing, care quality and employment outcomes. Lack of colleague and management support was found to be associated with the ability of ethnic minority workers to raise complaints (Howells et al., 2018); apply for promotion (Hudson et al., 2017); manage their wellbeing and work-life balance (Hussein, 2017b); or judge their workplace to be fair (Kline et al., 2017).

Hussein (2017b; 2018) examined the level of social support at work among ASC workers in England. The analysis showed that ethnic minority workers have significantly lower levels of social support (from both supervisor and co-workers) compared with White workers on similar roles. While controlling for a number of individual and workplace characteristics, social support only varied according to ethnicity, union membership and sector of work, with ethnic minority workers reporting some of the lowest social support levels. The study highlighted feelings of 'moral distress' were perceived as an everyday part of the job, and as a major factor in affecting workers wellbeing as well as a major cause of stress. The qualitative interviews identified training and support from supervisors and co-workers to be important in the ability of ethnic minority workers to deal with the adverse effects of moral distress (Hussein, 2017b). The findings that ethnic minority workers reported the lowest levels of social support is particularly concerning with the nature of care work.

A number of studies indicated similar findings related to a lack of support from line managers among low-paid ethnic minority workers in health and social care. Hudson et al. (2017) identified unsupportive line managers, lack of workplace advice and mentoring opportunities to be important factors in reduced positive social networks within the workplace leading to structural disadvantages for this group of workers.

Ethnicity and work outcomes in health and social care

The literature review identified a number of work outcomes that appear to be adversely impacted by the workers' ethnicity when focusing on low-paid work in health and social care. These are organised under three main themes:

1. pay and rewards

2. career progression, and
3. job satisfaction, stress and burnout.

There was little or no evidence that directly discussed differentials associated with ethnicity on other outcomes such as retention and intention to quit.

Pay and rewards

Women and ethnic minority workers' employment patterns followed gendered/ethnic division of labour across pay groups and occupations within health and social care (Howells et al., 2018). Ethnic minority staff in the NHS were more concentrated in support roles and middle bands (15% and 18% in England rising to 51% and 44% in London respectively) and significantly less represented in senior roles, where only 7% of very senior managers and 11% of senior managers came from an ethnic minority background (Kline et al., 2017).

A systematic review by Bimpong et al. (2020) identified an ethnic pay gap in the NHS, especially among NHS doctors across the UK, which has been shown to result in ethnic minority staff feeling less valued. Black people, in particular, were found to be the least paid among support workers and midwives in the NHS (Milner et al., 2020). Overall, ethnic minority workers were less represented in senior jobs and were systematically at the lower pay bands within job groups; White male health professionals were favoured for 'the most prestigious and most compensated jobs' (Milner et al., 2020). In Scotland, NHS Scotland data showed an ethnic pay gap of up to 3.4% for band 6 employees. However, the same data showed the complete lack of ethnic minority workers in higher bands or managerial roles, which is a concerning finding in itself (NHS Scotland, 2019).

The gender pay gap in NHS England varies by ethnicity, and the direction usually favours men for most ethnic groups. In 2017, the estimated median basic FTE pay gap between men and women was 8.6% in favour of men in NHS England. These differentials are significantly wider for women in most ethnic groups. Women from Asian ethnicities experience the largest gender pay gap, followed by those of mixed ethnicity and women of any other ethnic background. The gender pay gap only favours women in the case of women with Black ethnicity (Appleby, 2018).

Research highlights that assumptions around the 'vocational' nature of ASC work may lead to jobs in this sector being perceived and accepted as low-paid, low status and unqualified (Hussein, 2018; Farris, 2020). However, evidence on the experience of ethnic minority workers in ASC has indicated their over-representation in lower-paid work within the overall low-paid sector of ASC such as in frontline direct care jobs and under-representation in supervisory and managerial roles (SfC, 2020).

Using empirical research and employing structural equation modelling, Seifert and Wang (2018) showed that ethnic minority workers do feel unfairly paid compared with their White colleagues, but this had the least impact on their job satisfaction, which may be an indication of their strong public service motivation.

Career progression

Overall, NHS England ethnic minority staff were less likely to report a feeling that their Trust provides an equal opportunity for career progression (Kline et al., 2017). Similar views were shared among hospital pharmacists from Asian backgrounds (Howells et al., 2018). Among social service workers employed in local councils, similar observations were reported with ethnic minority workers significantly less likely to report their workplace as an' equal work environment' (Wang & Seifert, 2020).

In the NHS, ethnic minority workers, in general, are under-represented in senior positions and at the highest pay bands. Even when certain ethnic minorities were over-represented among doctors in the NHS, they were significantly less likely to be in the highest-paid groups (Milner et al., 2020; NHS Scotland, 2019). The same study found that Black people are under-represented both as doctors and among those highly paid. Among nurses, Asian people were the least paid among nurses and health visitors, while Black people were the least paid among support workers and midwives in the NHS (Milner et al., 2020). The authors concluded that the NHS still favours White and male professional staff for the 'most prestigious and most compensated' jobs.

Furthermore, analyses of WRES data, specific to NHS England, showed significant variations in the proportion of staff accessing non-mandatory training and continuing professional development, with White staff having a higher relative likelihood (1.15 in both 2018 and 2019) to receive such training compared with their ethnic minority counterparts in NHS trusts (WRES, 2020).

Hussein & Christensen (2017) analysed national workforce data combined with qualitative interviews with migrant men employed in adult social care. They highlighted that while there is a significant contribution of migrant men (who are on average more qualified and younger than their British counterparts) to the English care sector, they gain significantly less access to managerial roles, and are more concentrated in the private sector and more likely to work with 'challenging' service users. This suggests that migrant men as a group access the lowest part of the social care sector hierarchy in relation to working conditions and pay. The qualitative interviews identified several barriers this group faces in relation to career progression opportunities. These findings are consistent with the experience of British men from ethnic minority groups. Previous research highlights that despite the fact that men, in general, were more likely to occupy managerial and supervisory roles in adult social care, ethnic minority men were significantly less likely than their White counterparts to be employed in these roles (Hussein et al., 2016).

Job satisfaction, stress and burnout

The literature indicates that low job satisfaction has a negative impact on workers' wellbeing, job retention and potentially on the quality of services. In a systematic review, Bimpong et al. (2020) concluded that existing evidence indicates that UK NHS White employees were more likely to have higher job satisfaction than ethnic minority health professionals. They explained low job satisfaction among ethnic minority healthcare workers is derived from several sources; for example, many observe poor current and prospective pay levels. However, it was also clear that increasing pay alone was not sufficient to enhance overall job satisfaction; workplace relations and support was perceived to be very important in countering the effect of low pay. This is particularly concerning in relation to ethnic minority workers who were shown to have lower levels of in-work support (see section 3.3).

Employing survey and in-depth interview methodology, Hussein (2017b) highlights the lower levels of satisfaction in pay levels in the ASC despite a general acceptance of these pay levels and good overall job satisfaction among frontline care workers. The differentials between expected and reported job satisfaction among frontline care workers, including those from ethnic minority groups, were reported by other studies (Atkinson and Crozier, 2020; Etherington et al., 2018; Sahraoui, 2019). These studies found poor working conditions and insecure contracts among ethnic minority ASC workers, yet they also reported average levels of job satisfaction and commitment to the sector.

A study looking at job strain among adult social care workers found no significant differences according to ethnicity or nationality but did find that low social support and difficulties with personal finances was associated with high strain jobs Hussein (2018).

Spiliopoulos et al. (2020) further highlight the stress associated with migrants joining the ASC sector and living and working in a new culture, particularly in rural areas. Their findings provide insights into the strategies of resistance and adaptation adopted by individual migrant care workers to establish local networks and re-evaluate their own actions to deal with discrimination and exploitation in the workplace.

An area of growth in the ASC sector is domiciliary care services. This type of service employs a significant proportion of ethnic minority workers, especially in London, where demand for domiciliary services is highest. There is evidence from England of such services having the highest proportion of workers employed on zero-hours contracts (42%), especially among care workers (56%) (SfC, 2020). Domiciliary care services had the highest vacancy rates, at 9.0% and one of the highest turnover rates, especially for care workers (39%). Furthermore, several researchers (Atkinson and Crozier, 2020; Hussein and Christensen, 2017; Carter, 2018) argue that such growth is directly correlated with the marketisation of social care policy and has significant implications on employment relationships, fragmented work time and quality of jobs and care. Care is often commissioned by LAs at lower than its cost price and usually combined with insecure commissioning arrangements (moving away from block contracts). The research showed that fragmented time as a product of marketisation has significant negative effects on workers including dissatisfaction, stress and burnout.

The impact of COVID-19 on ethnic minority health and social care workers

Health workers

Frontline healthcare workers, and particularly ethnic minority workers, were at increased risk of both being infected with and dying from COVID-19, compared with the general public in the UK (Nguyen et al., 2020; Otu et al., 2020; Shields et al., 2020). The first 11 UK doctors to die from COVID-19 were of ethnic minority background. Of the NHS staff whose ethnicity was known, approximately 21% were of ethnic minority background, and this could be disaggregated into nursing and support staff (20%) and medical staff (44%). Emerging data showed that people from ethnic minority groups have accounted for 63% of all COVID-19 related deaths among NHS staff, 64% of deaths of nursing and support staff and 95% of deaths of medical staff (Otu et al., 2020).

Accounting for other risk factors, Nguyen et al. (2020) conducted post-hoc analyses showing that ethnic minority healthcare workers in the UK are at especially high risk of infection, with at least a fivefold increased risk of COVID-19 compared with the general White population. They found significant differences in PPE adequacy according to ethnicity; ethnic minority NHS staff reported reuse of or inadequate access to PPE more regularly, even when controlling for other factors, such as exposure to patients with COVID-19. Among NHS frontline workers, reuse of PPE or inadequate PPE were each associated with a subsequent increased risk of contracting COVID-19 (Nguyen et al., 2020). They concluded that ethnic minority healthcare workers were disproportionately affected by PPE adequacy and more likely to work in settings with greater exposure to patients with COVID-19.

Shields et al. (2020) examined the level of infection, including asymptomatic cases, of COVID-19 antibodies among healthcare workers. Based on a large sample (n=545) of NHS healthcare workers at the University Hospitals Birmingham NHS Foundation Trust in April 2020, they examined variations according to sex, gender, ethnicity, participants' postcode Index of Multiple Deprivation score and hospital department. They reported an overall SARS-CoV-2 seroprevalence of 24.4% among healthcare workers, which is significantly higher than the reported rates in the general population (6%). The levels of seroprevalence were highest in those working in housekeeping (34.5%) and lowest among those working in general surgery (13.0%). The relative risk was 2.34 among the housekeeping group compared with those working in intensive care. This might be linked to infection control measures employed within different hospital departments and occupation groups or related to an individual's personal characteristics, including ethnicity.

Employing advanced statistical analyses showed that ethnic minority workers were at significantly greater risk of testing positive for COVID-19 and women had higher levels of infection than men. However, these differences were not significant when controlling for other variables. The authors also highlighted that on average ethnic minority participants lived in more deprived areas than White participants; however, the level of area deprivation was not significantly associated with the probability of testing positive for COVID-19.

In Scotland, the proportion of ethnic minority patients among those seriously ill with COVID-19 was not higher than the proportion in the Scottish population generally (Meer et al., 2020). They call for closer monitoring of COVID-19 cases and deaths by ethnicity and deprivation indicators. They argue that large proportions of ethnic minority people, in general, live in more deprived areas and suffer from chronic diseases.

Social care workers

Hussein et al. (2020) examined the impact of COVID-19 on adult social care workers in the UK through a survey of 296 participants in July–August 2020. The analysis highlights significantly increased workload and working hours as well as a decline in reported job security among all groups of workers since the onset of the pandemic. Worryingly, a sixth of those who were forced to stop working during the pandemic reported receiving no pay at all during their self-isolation period(s). The analysis showed some differentials in the reported levels of self-isolation among ethnic minority workers, with 35% of ethnic minority, 32% of White non-British and 15% of White British care workers reporting self-isolation. However, after controlling for other factors, these differences were not significant.

The same survey also collected information on the perceived impact of the pandemic on workers' wellbeing. Nearly half reported their general health to have worsened, 60% reported an increase of incidents where their work had made them feel depressed, gloomy or miserable since the pandemic, and over half reported a reduction in the level of their work enthusiasm and optimism. The same study showed a reduced job satisfaction among a sizable group of ASC workers, with two-fifths (42%) of respondents indicating being a little or a lot less satisfied with their jobs since the onset of the pandemic. The reduction in job satisfaction was linked to reduced feelings of being safe in the workplace and lower levels of support from managers and colleagues.

Institutional racism and discrimination

Researchers argue that present structural racism observed in the experience of ethnic minority health and social care workers is structured by the racism of the past and continued institutional racism and in-group biases (Carter, 2018 Johansson et al., 2019; Khattab & Hussein, 2018). The same set of factors are also shown to be related to unequal outcomes through a process of limited social and at work opportunities.

Representation at senior levels

Lack of representation of ethnic minority healthcare workers among senior grades in the NHS was directly linked to institutional racism by several authors: for example, in the case of nurses (Qureshi et al., 2020); hospital pharmacists (Howells et al., 2018) and doctors (Milner et al., 2020). In the case of pharmacists, Howells et al. (2018) identified structural racism and discrimination as a specific reason for reduced career progression.

Covert and overt racism

Sahraoui (2019) identified the role of institutional racism as a key explanatory factor in the poor work experience of ASC migrant and ethnic minority workers, even with the existence of anti-discrimination laws in the UK. She highlights that such laws are insufficient in preventing the various forms of everyday racism.

Her research points out the different forms institutional racism can take, especially in ASC. Institutional racism is likely to manifest in the acceptance of different forms of racist attitudes from different groups within the workplace. Coverts forms of racism were frequently reported to be received from colleagues and managers, which are difficult to prove or act upon. On the other hand, when overt or direct racist actions were experienced by ethnic minority workers from service users, these were often not taken seriously by managers and supervisors. The health conditions, for example cognitive impairment, of those receiving care were considered a justification or excuse for unacceptable behaviour or attitudes. Furthermore, the study indicated that existing regulatory frameworks might deter managers to investigate such incidents further due to the administrative burden associated with the process of Safeguarding of Vulnerable Adults referrals.

Findings related to the different forms of covert and overt of racism and the complexities associated with reporting and dealing with them resonate with earlier findings on the same topic in the experience of ethnic minority workers in ASC in England (Stevens et al., 2012). Sahraoui (2019) identified three forms of racism: racial prejudice by care users; racist behaviour by colleagues; and harassment and discrimination by managers. This research provides evidence that ethnic minority and migrant workers in ASC in the UK are frequently exposed to the three forms of racism in the workplace.

Impact on overseas workers

Focusing on Zimbabwean social workers employed in the UK, Tinarwo (2017) examined how institutional and everyday racism impact their professional and personal lives. Based on 15 qualitative interviews, Tinarwo argued that structural and institutional racism adversely affects overseas qualified social workers' employment outcomes, including pay levels and opportunities for carer progression. One of the reasons for this was the disregard, and devaluation of higher qualifications obtained from home countries. This has led to many qualified workers starting their employment in the UK on the 'lowest grades' yet being allocated high caseloads.

Furthermore, pathways to career progression were not clear, and workers' applications for promotions were often rejected, leading to deskilling and the under-utilisation of skills. Tinarwo (2017) concluded that the effects of institutional racism affected the Zimbabwean social workers more significantly than individual racism. This study also highlighted the added burden on ethnic minority workers to exercise agency and come up with ways and means of countering strategies to deal, individually or collectively, with various forms of institutional racism. The onus of countering institutional racism and discrimination, thus, appeared to be accepted as the individual ethnic minority worker's responsibility rather than the responsibility of the organisation. These findings are consistent with other research across health and social care (Hammond et al., 2019; Howells et al., 2018; Stevens et al., 2012).

Outsourcing

In ASC, several researchers make a strong connection between the continued trend of outsourcing care services and treating people in need of care as 'consumers' and care services as products in creating fertile ground for institutional discrimination and stereotyping of certain expectations and roles associated with race and ethnicity (Christensen et al., 2017; Sahraoui, 2019). These are operated, primarily, through the accelerated use of private employment agencies and domestic arrangements. For example, Farris (2020), examining the impact of care commodification on the role of private and domestic placement agencies in care delivery in London, highlighted how these agencies foster some stereotypes linked to perceptions around the (un)skilled, racialised and feminised nature of care work.

Seifert and Wang (2018), based on a large survey of public service full-time employees (n=2,580), highlighted significant inequalities between ethnic minority and White staff in public services. The analyses showed ethnic minority employees to have significantly lower ratings in the equal work environment measure, which is specific to measuring institutional racism and includes three items: management is good at preventing discrimination; management takes complaints about bullying seriously; management takes complaints about racism seriously. They noted that management was likely to focus on organisational outcomes and tended to neglect when incidences of racism and discrimination are reported. They also pointed out the potential role of pre-existing perceptions among managers that ethnic minority workers tend to play the 'race card' when their performance is questioned and thus do not take reported incidents seriously.

In a further study, Wang and Seifert (2020) provide evidence of low perceptions of being fairly paid, receiving management support and having equal work environments among ethnic minority workers. They suggest that multiple sources of discrimination, harassment and bullying of ethnic minority groups are likely to explain these observations. It was not possible to establish if these findings were specific to low-paid workers in the social services' department due to lack of information on the sample breakdown in the published article.

Career progression

An ongoing study by Skills for Care[7] identifies that ethnic minority workers in the English ASC sector face challenges in the workplace associated with racism and discrimination which impact on their career progression opportunities. In late 2020, Skills for Care conducted a survey of more than 500 social care workers to investigate ethnic minority ASC workers' experience of the COVID-19 pandemic. The analysis of the survey responses identified three core challenges faced by ethnic minority workers in ASC: the prevalence of racism in the workplace; barriers to progression and representations; and increased mental and physical health burden during the pandemic. They also identified other issues resonating with research presented in this review including inequalities in pay; lack of confidence; feelings of lack of understanding and support in the workplace; and reports of lack of acceptance, recognition, respect and being valued by colleagues and managers.

Structural racism and the experiences of ethnic minority workers during COVID-19

Otu et al. (2020) point to potential links between a less empowered position of ethnic minority workers in the NHS and higher COVID-19 infection and death rates. They argue that due to lack of power, ethnic minority workers were more likely to work in hazardous situations; for example, when PPE supply is inadequate, compared with their White counterparts. They argue that continued and systemic discrimination are the underlying causes of lack of empowerment, citing significantly higher levels of reported incidents of bullying among ethnic minority NHS staff. Some of the COVID-19-related disparities are linked to pre-existing conditions as well as to social determinants of health. The latter is linked to inequalities in the distribution of income, work patterns, residency in large cities and over-crowded accommodations (Otu et al., 2020).

[7] Skills For Care (2020) Investigating the issues facing the BAME workforce and the impact of COVID-19 [accessed 17 March 2021]

In their study Shields et al. (2020) observed the difference in seroprevalence rates (pathogen levels) are more likely to be due to occupational risk. Their interpretation is supported by detailed analysis that accounted for the Index of Multiple Deprivation score of different workers. However, given that the sample was all located in one area it is likely that the range in the Index of Multiple Deprivation might not have been wide enough to capture the ethnic-income-inequalities and other social determinants of health highlighted by other researchers (Nguyen et al., 2020; Otu et al., 2020). Furthermore, their analysis still showed significantly higher risks among ethnic minority healthcare workers after accounting for department and other factors.

Common experiences of low-paid workers in health and adult social care

The literature review points to a number of common issues experienced by low-paid workers in health and social care across all ethnicities. It is worth noting that addressing some common themes of disadvantages would be beneficial to all workers in the sector, especially ethnic minority workers. First, evidence indicates a certain level of incidents of bullying and harassment from patients to a variety of healthcare professionals in the NHS (Kline et al., 2017).

Very low wages and insecure contracts are evident across all frontline jobs in ASC. For example, Hussein (2017a) estimates between 10% and 13% of ASC workers across all ethnicities are effectively paid under the national minimum wage. Furthermore, the growth of domiciliary and live-in care associated with an increased role of the private sector leads to escalation in insecure contracts and fragmented work arrangements (Atkinson and Crozier, 2020; Farris, 2020; Hudson and Runge, 2020; Hussein and Christensen, 2017).

Hudson et al. (2017) examined the relationship between cultural difference, social connections and progression opportunities among low-paid workers in different sectors, including health and social care services. Their findings highlight the lack of progression pathways for all low-paid workers. They link such lack of opportunities to a process of ‘downsizing and delayering’ associated with reduced budgets and restructuring measures observed particularly in the health and social service case studies. Low-paid workers in this study identified very few opportunities for progression and a reluctance to apply for promotion due to job insecurity. Furthermore, available training opportunities in health and social care were geared towards meeting mandatory requirement within existing jobs rather than being a mechanism for an improved career path. These findings were more pronounced within ethnic minority groups and women.

In ASC, nearly a third of all frontline workers work in high-strain jobs, which are linked in the literature with adverse health and work outcomes. The prevalence of having high-strain jobs was determined mainly by the nature of work (hands-on care) and income hardship with no significant difference in relation to ethnicity (Hussein, 2018).

Gender has a clear impact on work outcomes with women systematically paid less across all ethnicities in the NHS except among Black/Black British groups (Appleby and Schlepper, 2019). Furthermore, in both health and social care women with families and caring responsibilities have less favourable work outcomes including lack of career opportunities, promotion and training (King et al., 2020).

Interventions to reduce ethnic inequalities in the workplace

This section draws on findings related to strategies and interventions specific to low-paid work in health and social care that were identified from the main review. Furthermore, a more general literature search was undertaken to identify interventions aimed at reducing ethnic inequalities in health and care workplaces, but not exclusive to low-paid jobs.

Policies to tackle discrimination

At the national level, the literature highlights the importance of developing and implementing national intervention policies and laws aimed specifically to tackle labour market discrimination and enhance the experience of ethnic minority workers (Gillen et al., 2017; Hudson et al., 2017). National and local audit and diversity monitoring at the sector level have also been suggested as mechanisms to identify disadvantaged groups (Carter, 2018).

Employer action

Proactive and positive actions from employers are needed to address the current 'low pay traps and restrictive opportunities' of ethnic minority workers identified by several researchers (Hudson et al., 2017; Sarfo-Annin, 2020). This might involve affirmative actions including the 'Rooney Rule', where at least one candidate from an ethnic minority should be called for an interview. However, Sarfo-Annin (2020) warned against adapting blanket affirmative actions, in this case when recruiting doctors, in relation to potential risks of creating a group of 'sub-prime' ethnic minority doctors and drew attention to the failure of such rules when originally introduced in American football in 2003. The author stressed the importance of collecting more granular data and metrics to ensure different sub-groups of ethnic minority medical doctors are given a fair opportunity to progress to leadership positions.

Interventions to reduce inequalities in the workplace may involve change at the organisational level, such as introducing procedures to raise awareness of bullying and provide a bullying reporting mechanism. They can also involve individual-level interventions such as the provision of training and education to change behaviours or perceptions (Gillen et al., 2017), although this approach may place responsibility on the victims of bullying rather than the perpetrators. Interventions to reduce discrimination in recruitment practices include introducing discrimination law, monitoring the diversity of the organisation, and anonymisation of the recruitment process as much as possible (Larsen and Di Stasio, 2019; Lloyd, 2010).

Support structures

King et al. (2020) highlight the role of creating 'community of practice' as an important mechanism of support among healthcare professionals. These communities would include line managers, tutors and workers with similar roles. For these to be effective, they need to receive institutional consensus and be formally set up. Part of this community's role would be to facilitate career progression and empower workers' voice. There are several identified benefits of having positive face-to-face workplace relationships (Hudson et al., 2017). However, the potential role of virtual national support communities, organised through social media for example, was also highlighted (King et al., 2020). The provision of continued professional development, including mentoring support to help career progression among ethnic minority health and social care workers, was identified as an important strategy, especially for newly created roles such as support workers (King et al., 2020) and new recruits (Hammond et al., 2017; Howells et al., 2018).

Collective interventions

Collective movements and trade unions (Seifert and Wang, 2018) are highlighted as important mechanisms to enhance ethnic minority workers' voices and facilitate positive change in the workplace. However, the uptake of ethnic minority workers, especially those in low-paid occupations within the health and social care sector, is relatively low (Carter, 2018; Hussein, 2018). There are also questions related to the belief of particular groups of workers in the ability of trade unions to represent their case effectively (Wang and Seifert, 2020). For example, Seifert and Wang (2018) found that ethnic minority employees in the public sector belong to trade unions at similar rates to their White counterparts. However, they remain under-represented in terms of union activists and officials. They explain this mismatch in relation to the extent to which certain ethnic minority groups believe the unions are able to fight their cause. Several studies suggest that other forms of collectivism associated with cultural, ethnic and racial networks are potentially more effective in providing support and negotiating the position of ethnic minority workers in health and social care (Carter, 2018; Tinarwo, 2017).

Discussing White privilege

A growing body of research investigates the impact of exposure to evidence of privileged status, such as when training is specific to race equalities and unconscious bias, on attitudes and behaviours of individuals in the workplace (Gillen et al., 2017). This body of literature presents mixed findings on the consequences of exposure to advantage/disadvantage status through these workplace training programmes (Atewologun et al., 2018). A number of studies have reported positive effects, including awareness-raising, potentially shifting attitudes and enhancing the feelings of collective 'guilt' among majority group members (Migliaccio, 2020). These effects are perceived to improve attitudes towards minority groups, such as ethnic minority workers, in the workplace.

However, several studies found negative effects, including more prevalent or consolidated attitudes towards minority groups. Explanations for changes in attitudes on exposure to privilege have often focused on what has been termed 'white fragility', whereby White individuals, as majority group members experience stress as a consequence of challenges to the racial status quo and result in the activation of greater prejudice and discrimination towards the minority group as a defensive mechanism. Studies show when White workers are 'exposed' to evidence related to White privilege and race inequalities, they report significantly higher levels of hardship and beliefs in 'personal' privilege, yet their beliefs in 'White privilege' remain unchanged compared with the control group (Murdock and McAloney-Kocaman, 2019). Thus, anti-bullying or unconscious bias training in the workplace is unlikely to yield a high level of positive change on its own (Atewologun et al., 2018). To the contrary, these training programmes may increase and legitimise institutional racism and bullying behaviour and attitudes.

Safe spaces

A report by The Kings Fund provides three case studies of NHS providers who introduced interventions specifically to make it safer to raise concerns related to race and enable the development and career progression of ethnic minority healthcare workers (Ross et al., 2020). The first set of interventions was based on creating strong staff networks where ethnic minority staff can feel safe to raise concerns. Staff networks were supported by the leadership team with mechanisms in place to ensure concerns were acted upon. The staff networks are inclusive and have membership from all staff groups. They are chaired by an ethnic minority staff member and meet regularly. However, the same report identified several challenges in setting up and maintaining these networks. The challenges included a considerable amount of unpaid work by members, especially the ethnic minority staff who chair and organise meetings. The authors also reported incidents of staff being discouraged from joining these networks and some unintended consequences of resentment among colleagues who might feel excluded. These adverse consequences resonated with the findings of an NHS England national survey in 2018.

Career progression

Interventions to enable development and career progression among ethnic minority workers in the NHS as identified by Ross et al. (2020) included targeted development programmes and addressing organisational barriers. The authors provided examples of the 'Moving Forward' programme and conducting regular 'Sharing Perspectives' workshops. While they point to a generally positive uptake and perception of these interventions among both ethnic minority and White NHS staff, they highlight the potential for these to be seen as 'divisive' by some White colleagues.

Gaps in the literature

The current review revealed some important knowledge gaps in the evidence of differential work outcomes of ethnic minority workers in health and adult social care and particularly those working in low-paid jobs. The most apparent gap is the absence of research specific to the nations separately. Most of the evidence is drawn from data specific to England or from small-scale interview data across the UK with no specific regional or national focus.

While the review identified almost an equal number of outputs from the health and ASC sectors, the methods and data used for the two groups are quite different. Most evidence related to the NHS was based on large surveys or data specific to race equality measure. The role of the NHS England Workforce Race Equality Standard (WRES) was evident in creating more detailed information on the experience of ethnic minority healthcare staff over the past several years. While there are some aggregate data on ethnic minority healthcare staff provided by NHS Scotland and Wales, there is no equivalent to the detailed WRES survey data in either Scotland or Wales.

For adult social care, Skills for Care data generated some useful information on some of the working conditions of ethnic minority workers in England. The Scottish Social Services and Social Care Wales also provided aggregate data on various elements of the care workforce, yet with no specific focus on ethnicity. There are a number of limitations associated with the ASC data across the three nations. The first is the source of reporting, mainly by employers, and the second is the fact that the data are limited to a few aggregate characteristics. The evidence presented about ASC in this report is primarily based on the Skills for Care dataset, as this is the most utilised in research, combined with qualitative studies with the exception of a few studies that employed national workforce surveys.

Most studies identified adapted either cross-sectional quantitative design or qualitative interviews with a small number of participants. This type of research allows the identification of correlations and associations between different factors and outcomes, rather than demonstrating causation. There have been few publications where the studies' design was longitudinal, and the analyses investigated path and structural relations allowing to draw some causational relations. These were primarily focused on health research, and only one such design focused on the experience of ASC ethnic minority workers.

Many of the identified publications had a range of research questions that included the experience of ethnic minority health and care workers but not as the core research topic.

Discussion

Ethnic minority workers make a significant contribution to the health and social care workforce in Britain. Overall, they are concentrated in lower-paid jobs and under-represented in management and senior positions in both sectors. In the NHS, evidence points to adverse differentials in recruitment, pay, promotion and incidents of bullying and mistreatment from managers and colleagues among ethnic minority workers when compared with White colleagues (Kline et al., 2017; WRES, 2020). Evidence from the ASC sector is very similar with a higher prevalence of ethnic minority workers in private, domiciliary and agency work, with associated high prevalence of insecure and fragmented work, reliance on employment agencies for recruitment and reduced social support at work (Atkinson and Crozier, 2020; Farris, 2020; SfC, 2020). Furthermore, ethnic minority workers appear to receive higher levels of abuse and mistreatment from service users than White British workers in ASC.

Many researchers link the over-representation of ethnic minority workers in low-paid jobs, including in health and social care, to historical segmentation and selection practice into certain sectors and occupations (Hudson et al., 2017). Furthermore, income reliance due to socio-economic disadvantages and having families and caring responsibilities act as push factors to accept low-paid, local jobs in social care among ethnic minority workers (King et al., 2020). These ‘sorting’ processes of certain groups into lower-paid occupations exacerbate racialised and gendered stereotypes of ASC work, particularly that involving domiciliary and live-in care (Atkinson and Crozier, 2020; Farris, 2020).

Workplace experience

Ethnic minority workers in health and ASC sectors in Britain are shown to be negatively and significantly exposed to several workplace experiences and outcomes. These include downward mobility; higher levels of overt and covert harassment and bullying incidents; reduced social support at work; higher likelihood to enter formal disciplinary procedures; and lower levels of job satisfaction. These experiences have negative consequences on ethnic minority health and care workers, including levels of stress and burnout (Johansson et al., 2019; Hussein, 2018). There is also evidence that ethnic minority staff in these settings feel less valued by the organisations and have less belief in their work environment to be fair and able to deal effectively with harassment and bullying (Bimpong et al., 2020; Howells et al., 2017; Kline et al., 2017; Wang and Seifert, 2020). Lack of managerial support and reduced social networks in the workplace, beyond the immediate job roles, have significant negative implications on the wellbeing of and career progression opportunities for ethnic minority workers.

Paradoxically, low-paid ethnic minority workers, particularly in ASC, report average to high levels of job satisfaction and commitment despite differential work experiences and outcomes. Such paradox was explained to be related to the nature of care work and the inherent expected levels of reward from helping others. These are also linked to the motivations of this group of workers and how they might attach a sense of pay sacrifice to be an important element of their self-worth, where they place the value of supporting vulnerable people ahead of their own needs (Atkinson and Crozier, 2020; Etherington et al., 2018; Hussein, 2017b; Sahraoui, 2019).

Career progression

Several explanations for lack of career progression among ethnic minority health and ASC workers were identified in the literature. One of the main factors related to ‘white hierarchy’ and ‘ruling relations’ between senior teams and other workers and institutional racism where unspoken rules favour White and male professional staff for the ‘most prestigious and most compensated’ jobs (Howells et al., 2018; Milner et al., 2020; Qureshi et al., 2020; Sahraoui, 2019).

Other mechanisms are linked to ethnic minority workers internalising these factors and not being able to see oneself ‘fitting in’ within the ‘white crowd’ of senior colleagues and lack of a role model in senior roles (Qureshi et al., 2020). Furthermore, religion and social markers interact with ethnicity and gender, further discouraging individuals from applying for promotions (Howells et al., 2018).

Pre-existing perceptions

A strong body of literature identified systematic pre-existing conceptions of the 'qualities' of certain individuals and groups of workers as key explanatory factors for the observed differentials in the experience and outcomes of ethnic minority workers in health and social care. The effect is larger when different layers of identities interact, for example, race and gender, with the experience of those who are most visible (e.g., Black men in rural areas) or who belong to certain religious groups associated with certain public connotations (e.g., Muslims) as being exposed to the least favourable conditions and experiences (Spiliopoulos et al., 2020; Stevens et al., 2012; Younis and Jadhav, 2020).

Impact of COVID-19

The COVID-19 pandemic has affected health and care workers disproportionally compared with the general public; this was particularly the case for ethnic minority staff. The levels of COVID-19 infection and related death rates were significantly higher among people from ethnic minorities, particularly those working in health and care settings when compared with the White population (Houlihan et al., 2020; Nguyen et al., 2020; Otu et al., 2020; Shields et al., 2020). Furthermore, evidence shows that all health and care workers have been put under immense work pressures including high levels of workload, feelings of being unsafe at work with negative implications on their wellbeing (Hussein et al., 2020; Nguyen et al., 2020). These differentials in infection and death rates according to ethnicity are attributes of a less empowered position of ethnic minority workers and accepting working in risky situations (Otu et al., 2020), occupational risks associated with ethnic minority workers being concentrated in lower-paid jobs and roles where infection control measures might be variable (Nguyen et al., 2020), and pre-existing socio-economic inequalities (Shields et al., 2020).

Institutional and structural racism

Institutional and structural racism was identified by several studies as the root cause of such differential experiences (Birks et al., 2017; Joseph, 2019; Howells et al., 2019). These were particularly evident among Black ethnic minorities, where authors referred to advantages of 'whiteness' and 'white hierarchy' as a hidden source of White privilege at work (Joseph, 2019; Howells et al., 2019), as well as ascribing deficiency to Black workers' credentials and qualifications (Joseph, 2019; Tinarwo, 2017). The mechanism, according to the review, is associated with ethnic minority workers perceiving themselves to be distanced from the senior 'white' managers where they report discouragements and rejection of promotion applications. This affects both newly arrived migrants to the UK as well as second generations and more established ethnic and religious groups. The social connections between employees and managers embody flows of power and influence drawn on in recruitment and promotion processes that privilege some ethnic groups (Howells et al., 2018; Qureshi et al., 2020; Milner et al., 2020; Sahraoui, 2019).

Furthermore, the evidence showed that the onus of navigating and countering these differentials were in the majority placed on the individual ethnic minority workers, who report needing to fit in and comply with a set of stereotypes and pre-existing (mis)conceptions (Hammond et al., 2017).

However, this review also highlights some common, less favourable conditions of all workers in low-paid jobs in health and social care regardless of ethnicity. This is particularly evident in ASC, where a significant number are estimated to be paid less than the National Living Wage (Hussein, 2017a). Furthermore, all low-paid workers in these sectors appeared to lack career progression opportunities (Hudson and Runge, 2020; Hudson et al., 2017); to be exposed to mistreatment from patients and service users (Kline et al., 2017); and to be at a high risk of stress and burnout (Hussein, 2018). Several authors linked inadequate funding, marketisation, and the increased share of private organisations in ASC to adverse working conditions and insecure employment for a sizable group of workers in the sector (Atkinson and Crozier, 2020; Farris, 2020; Hussein and Christensen, 2017; Sahraoui, 2019).

Interventions

This review collated evidence of interventions aimed at tackling ethnic inequalities in health and social care workplaces. However, none of the interventions identified were specific to ASC. Several strategies have been identified to operate at the national, organisation and individual workers' levels. At the national level, equality policies and laws were judged to be essential to facilitate pathways to equality in the workplace (Carter, 2018; Hudson et al., 2017; Gillen et al., 2017). However, these were not sufficient to deal with day-to-day racism and discrimination, which is hard to prove and act upon (Sahraoui, 2019).

Organisational change and in-work training were suggested by a number of researchers (Gillen et al., 2017; Migliaccio, 2020; Ross et al., 2020). However, evidence related to the effectiveness of anti-discriminatory staff training is inconclusive and might lead to further negative effect to the extent of further legitimising bullying and racist behaviour (Atewologun et al., 2018; Murdoch and McAloney-Kocaman, 2019). Positive and affirmative actions that favour ethnic minority workers were suggested by some authors as a way of responding to observed inequalities (Hudson et al., 2017), however, the effectiveness and fairness of such an approach were questioned by others (Sarfo-Annin, 2020).

Having a 'collective' voice, either through trade union membership or other social networks revolving around cultural or ethnic identities, was promoted as a potential way to negotiate positive change for ethnic minority workers (Carter, 2018; Seifert and Wang, 2018; Tinarwo, 2017). However, there was some scepticism in the effectiveness of these mechanisms associated with the trust ethnic minority workers have in trade unions as well as the leverage ethnic social networks might have on the sector (Seifert and Wang, 2018). Other forms of collectivism revolved around 'communities of practice' or building social support within the workplace (Hudson et al., 2017; King et al., 2020). In work, support was shown to be one of the most important factors to achieve positive work experience and outcomes. Thus, such communities of practice are likely to be effective if well-supported by the organisation (Ross et al., 2020).

Conclusions

This rapid review provides evidence of the experience of ethnic minority health and social care workers in Britain based on research published since 2017. Evidence showed that workers from ethnic minorities make significant contributions to the health and adult social care sectors. Despite this, they faced several adverse work experiences and outcomes. Differentials were evidenced across the whole process of employment, from the recruitment process to career progression and burnout. Ethnic pay-gap and under-representation of workers in senior positions in both sectors appeared to be persistent and ongoing. The evidence further highlighted that effects related to ethnicity were further associated with visible markers, gender, migration status and religion. Workers with visible social markers, such as those belonging to Black ethnicities, were most adversely affected.

A strong body of literature linked the observed poorer work outcomes among ethnic minority workers in health and social care to historical and current institutional racism and discrimination. These were manifested in sorting workers into certain occupations and pay bands and creating power hierarchies within the workplace, which further influenced workers' abilities to progress. Furthermore, especially in ASC, the marketisation, outsourcing and mixed-funding model appeared to negatively affect most low-paid workers' job security and outcomes. Ethnic minority workers were exposed to more incidents of mistreatment and lack in-work social support compared with their White British counterparts.

The COVID-19 pandemic has further affected the health and ASC frontline workers and particularly ethnic minority workers. There is also evidence of increased workload and working hours, fatigue and depressive feelings as well as a concerning level of unpaid leave among ASC workers who are already low paid. The review identified a number of interventions and strategies to enhance the experience of ethnic minority workers in health and care and reduce observed inequalities. Enhancing supportive social networks at work and ensuring ethnic minority workers have a collective voice were highlighted as effective ways to make positive change in the workplace.

References

Appleby J. (2018). Ethnic pay gap among NHS doctors. BMJ, 362.

Appleby, J., & Schlepper, L. (2019). The gender pay gap in the English NHS Analysis of some of the underlying causes. London: The Nuffield Trust.

Atewologun, D., Cornish, T. & Tresh, F. (2018). Unconscious Bias Training: An Assessment of the Evidence for Effectiveness (No. 113). EHRC Report.

Atkinson, C., & Crozier, S. (2020). Fragmented time and domiciliary care quality. Employee Relations: The International Journal.

Barnard, C., Ludlow, A. & Butlin, S. F. (2018). Beyond Employment Tribunals: Enforcement of Employment Rights by EU-8 Migrant Workers, Industrial Law Journal, 47(2): 226–262.

Bimpong, K. A. A., Khan, A., Slight, R., Tolley, C. L., & Slight, S. P. (2020). Relationship between labour force satisfaction, wages and retention within the UK National Health Service: a systematic review of the literature. BMJ open, 10(7), e034919.

Birks, M., Cant, R. P., Budden, L.M, Russell-Westhead, M., Özçetin, Y.S. & Tee, S. (2017). Uncovering degrees of workplace bullying: A comparison of baccalaureate nursing students' experiences during clinical placement in Australia and the UK. Nurse Education in Practice, 25: 14–21.

British Medical Association (2021). COVID-19: The risk to BAME doctors. 24 August 2021 [accessed on 5/10/21].

Butt, M. F., Salmon, L., Mulamehic, F., Hixon, A., Moodambail, A. R., & Gupta, S. (2019). Integrating refugee healthcare professionals in the UK National Health Service: experience from a multi-agency collaboration. Advances in Medical Education and Practice, 10, 891.

Carter, N. G. (2018). Black Workers and BME networks organising against racism in the NHS workplace (Doctoral dissertation, London Metropolitan University).

Christensen, K., Hussein, S. & Ismail, M. (2017). Migrant intelligence shaping work destination choice: the case of long-term care work in the United Kingdom and Norway. European Journal of Aging. 14(3): 219-232.

Data Cymru (2019). Social Care Wales - Workforce Profile 2018: Commissioned Care Provider Services [accessed 15 March 2021].

Ethel, Y. & William C. (2020). Identifying Moderators in the Link between Workplace Discrimination and Health/Well-Being. Frontiers in Psychology, 11, 58.

Etherington, D., Jeffery, R., Thomas, P., Brooks, J., Beel, D., & Jones, M. (2018). Forging an inclusive labour market-empowering workers and communities: an interim report on low pay and precarious work in Sheffield. Project Report. Sheffield, Sheffield Trades Union Council.

Farris, S. (2020). The business of care: Private placement agencies and female migrant workers in London. Gender Work and Organisation, DOI: 10.1111/gwao.12520.

Figgett, D. (2017), 'Recruitment and retention in adult social care: secrets of success.' Leeds: Skills for Care.

Gillen, P. A., Sinclair, M., Kernohan, W. G., Begley, C. M., & Luyben, A. G. (2017). Interventions for prevention of bullying in the workplace. Cochrane Database of Systematic Reviews, (1).

Hammond, J., Marshall-Lucette, J., Davies, N., Ross, F. & Harris, R. (2017). Spotlight on equality of employment opportunities: A qualitative study of job seeking experiences of graduating nurses and physiotherapists from black and minority ethnic backgrounds, International Journal of Nursing Studies, 74, 172–180.

Haque, Z., Becares, L., & Treloar, N. (2020). Over-exposed and under-protected: The devastating impact of COVID-19 on Black and Minority Ethnic communities in Great Britain [accessed 19 April 2021].

Heath, A. and Stasio, V. Di (2019), 'Are employers in Britain discriminating against ethnic minorities?' GEMM Project, European Commission.

Heath, A. F., & Di Stasio, V. (2020). Racial discrimination in Britain, 1969–2017: a meta-analysis of field experiments on racial discrimination in the British labour market. The British Journal of Sociology, 70(5), 1774-1798.

Houlihan C, Vora N, Byrne T, et al. (2020). SARS-CoV-2 virus and antibodies in front-line health care workers in an acute hospital in London: preliminary results from a longitudinal study [accessed 15 March 2021].

Howells, K., Bowera, P. & Hassell, K. (2018). Exploring the career choices of White and Black, Asian and Minority Ethnic women pharmacists: a qualitative study. International Journal of Pharmacy Practice, 26: 507–514.

Hudson M, Netto G, Noon M, Sosenko F, de Lima P, Kamenou-Aigbekaen N. (2017). Ethnicity and low wage traps: favouritism, homosocial reproduction and economic marginalization. Work, Employment and Society. 31(6):992–1009.

Hudson, N., & Runge, J. (2020). Recruitment of workers into low-paid occupations and industries: an evidence review. Manchester: Equality and Human Rights Commission.

Hussein, S. (2017a). 'We don't do it for the money'... The scale and reasons of poverty-pay among frontline long-term care workers in England. Health and Social Care in the Community. 25(6): 1817–1826.

Hussein, S. (2017b) The English Social Care Workforce: The vexed question of low wages and stress. In Christensen and Billing (eds.) The Routledge Handbook of Social Care Work Around the World, pp.74–87. London: Routledge.

Hussein, S. (2018). Job demand, control and unresolved stress within the emotional work of long-term care in England. International Journal of Care and Caring, 2(1), 89–107.

Hussein, S. and Christensen, K. (2017). Migration, gender and low-paid work: on migrant men's entry dynamics into the feminised social care work in the UK. Journal of Ethnic and Migration Studies, 43(5), 749–765.

Hussein, S., Manthorpe, J. and Ismail, M. (2014). Ethnicity at work: the case of British minority workers in the long-term care sector, Equality, Diversity and Inclusion, 33 (2): 177–192.

Hussein, S., Ismail, M. and Manthorpe, J. (2016). Male Workers in the Female-dominated Long-term Care Sector: Evidence from England. Journal of Gender Studies 25 (1): 35–49.

Hussein, S., Saloniki, E., Turnpenny, A., Collins, G., Vadean, F., Bryson, A., Forth, J., Allan, S., Towers, A.M., Gousia, K. and Richardson, L. (2020). COVID-19 and the Wellbeing of the Adult Social Care Workforce: Evidence from the UK. The Personal Social Services Research Unit, University of Kent.

Iob, E., Frank, P., Steptoe, A., & Fancourt, D. (2020). Levels of severity of depressive symptoms among at-risk groups in the UK during the COVID-19 pandemic. JAMA network open, 3(10), e2026064-e2026064.

Johnson, J., Cameron, L., Mitchinson, L., Parmar, M., Opio-te, G., Louch, G., & Grange, A. (2019). An investigation into the relationships between bullying, discrimination, burnout and patient safety in nurses and midwives: is burnout a mediator? Journal of Research in Nursing, 24(8), 604–619.

Joseph, E. (2019). Discrimination against credentials in Black bodies: counter stories of the characteristic labour market experiences of migrants in Ireland. British Journal of Guidance & Counselling, 47(4), 524–542.

Kerr, S. (2018). Race at work 2018. London: Department for Business, Energy and Industrial Strategy.

Khattab, N. & Hussein, S. (2018). Can religious affiliation explain the disadvantage of Muslim women in the British labour market? Work, Employment and Society. 32(6) 1011–1028.

King R, Ryan T, Wood E, Tod A, Robertson S. (2020). Motivations, experiences and aspirations of trainee nursing associates in England: a qualitative study. BMC Health Services Research. 20(1):802.

Kingston, G., McGinnity, F., & O'Connell, P. J. (2015). Discrimination in the labour market: nationality, ethnicity and the recession. Work, Employment and Society, 29(2), 213–232.

Kline, R., Naqvi, H., Razaq, S. A., & Wilhelm, R. (2017). NHS workforce race equality standard. 2016 Data analysis report for NHS Trusts.

Larsen, E. N. and Di Stasio, V. (2019), 'Pakistani in the UK and Norway: different contexts, similar disadvantage. Results from a comparative field experiment on hiring discrimination', Journal of Ethnic and Migration Studies. Doi:10.1080/1369183X.2019.1622777

Living Wage Foundation (2020). Employee jobs paid below the living wage: 2020. London: The Living Wage Foundation [accessed 15 March 2021].

Lloyd, J. (2010). Ending ethnic discrimination in recruitment. London, UK: The Strategic Society Centre.

Macpherson, W. (1999). The Stephen Lawrence Inquiry. London: TSO.

Manthorpe, J., Harris, J., Moriarty, J., & Stevens, M. (2018). Workforce Diversity and Conflicts in Care Work: Managers' Perspectives. International Journal of Care and Caring, 2(4), 499–513.

Meer, N., Akhtar, S., & Davidson, N. (2020). Taking Stock: Race Equality in Scotland.

Migliaccio, L. (2020). Framing Effects of Racial Inequity in the Workplace: Emotional, Cognitive, and Trait Influences. Hofstra University.

Milner, A., Baker, E., Jeraj, S., & Butt, J. (2020). Race-ethnic and gender differences in representation within the English National Health Service: a quantitative analysis. BMJ open, 10(2).

Moher, D., Liberati, A., Tetzlaff, J. & Altman, D.G. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ; 339: b2535.

Murdoch, A., & McAloney-Kocaman, K. (2019). Exposure to evidence of White Privilege and perceptions of hardships among White UK residents. Race and Social Problems, 11(3), 205–211.

National Health Services, National Services Scotland (2019). Equal Pay Gap Report [accessed 15 March 2021].

Nguyen, L. H., Drew, D. A., Graham, M. S., Joshi, A. D., Guo, C. G., Ma, W., ... & Zhang, F. (2020). Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study. The Lancet Public Health, 5(9), e475-e483.

Office for National Statistics (2020a). Deaths involving the coronavirus (COVID-19) among health and social care workers in England and Wales, deaths registered between 9 March and 20 July 2020. London: ONS [accessed 23 December 2020].

Office for National Statistics (2020b). Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020. London: ONS. [accessed 23 December 2020].

Otu, A., Ahinkorah, B. O., Ameyaw, E. K., Seidu, A. A., & Yaya, S. (2020). One country, two crises: what Covid-19 reveals about health inequalities among ethnic minority communities in the United Kingdom and the sustainability of its health system? International Journal for Equity in Health, 19(1), 1–6.

Qureshi, I., Ali, N., Randhawa, G. (2020). British South Asian male nurses' views on the barriers and enablers to entering and progressing in nursing careers. Journal of Nursing Management. 28: 892–902.

Rafferty, A. (2020). Skill Underutilization and Under-Skilling in Europe: The Role of Workplace Discrimination. Work, Employment and Society, 34(2), 317–335.

Reskin, B. F., & Roos, P. A. (2009). Job queues, gender queues: Explaining women's inroads into male occupations. Temple University Press.

Ross, S., Jabbal, J., Chauhan, K., Maguire, D., Randhawa, M. & Dahir, S. (2020). Workforce race inequalities and inclusion in NHS providers. London: The King's Fund.

Royal College of Physicians (2018). Health and social care in England: a quick guide. London: Royal College of Physicians.

Rzepnikowska, A. (2019). Racism and xenophobia experienced by Polish migrants in the UK before and after Brexit vote, Journal of Ethnic and Migration Studies, 45:1, 61–77.

Sahraoui, N. (2019). Racialised Workers and European Older-Age Care. Springer International Publishing.

Sarfo-Annin, J. K. (2020). Ethnic inclusion in medicine: the ineffectiveness of the 'Black, Asian and Minority Ethnic' metric to measure progress. BJGP open, 4(5).

Scottish Social Services Council (2020). Scottish Social Service Sector: Report on 2019 Workforce Data. An Official Statistics Publication for Scotland [accessed 15 March 2021].

Seifert, R., & Wang, W. (2018). Race discrimination at work: the moderating role of trade unionism in English local government. Industrial Relations Journal, 49(3), 259–277.

Serafini, K., Coyer, C., Speights, J. B., Donovan, D., Guh, J., Washington, J., & Ainsworth, C. (2020). Racism as experienced by physicians of color in the health care setting. Family Medicine, 52(4), 282–287.

Shields, A., Faustini, S. E., Perez-Toledo, M., Jossi, S., Aldera, E., Allen, J. D., & Richter, A. G. (2020). SARS-CoV-2 seroprevalence and asymptomatic viral carriage in healthcare workers: a cross-sectional study. Thorax, 75(12), 1089–1094.

Skills for Care (2020). The state of the adult social care sector and workforce in England. October 2020. London: Skills for Care.

Social Care Wales (2021). Annual survey of local authority commissioned services [accessed 15 March 2021].

Spiliopoulos, G., Cuban, S. & Broadhurst, K. (2020): Migrant Care Workers at the Intersection of Rural Belonging in Small English Communities, Journal of Immigrant & Refugee Studies, DOI: 10.1080/15562948.2020.1801941.

Stevens, M., Hussein, S. & Manthorpe, J. (2012). Experiences of racism and discrimination among migrant care workers in England: Findings from a mixed-methods research project, Ethnic and Racial Studies, 35:2, 259–280.

Tilley, J., Exley, S., & Heath, A. (2004). Dimensions of British identity. In A. Park, J. Curtice, K. Thomson, C. Bromley, & M. Phillips (Eds.), British Social Attitudes: the 21st Report. London: Sage.

Tinarwo, M. T. (2017). Discrimination as experienced by overseas social workers employed within the British welfare state. International Social Work, 60(3), 707–719.

Wang, W., Seifert, R. (2020). Ethnic minority Staff and Public Service Motivation: The Mediating Role of Perceived Fairness in English Local Government. Journal of Business Ethics 161, 653–664.

Warren, T. & Lyonette, C. (2020). Carrying the work burden of the COVID-19 pandemic: working class women in the UK. Nottingham University, Warwick Institute for Employment and Research, Women's Budget Group.

Weekes-Bernard, D. (2017). Poverty and ethnicity in the labour market. York: Joseph Rowntree Foundation.

Workforce Race Equality Standard [WRES] (2019). NHS workforce race equality standard: 2018 data analysis report for NHS trusts. The WRES Implementation Team: NHS England.

Younis, T. and Jadhav, S. (2020), 'Islamophobia in the National Health Service: an ethnography of institutional racism in PREVENT's counter-radicalisation policy'. Sociology of Health and Illness, 42: 610–626 [accessed 15 March 2021].

Appendix 1: Review protocol

Definitions

Low-paid work in health and social care

Low-paid work is defined as roles paying up to around £10 per hour, such as care assistants and care workers; personal assistants; porters and cleaners. The review is set with the following primary and sub- research questions as set by the EHRC brief. An initial search and review of available hourly pay data and job advertisements in the health and social care sectors were made. This initial review identified low-paying job roles in health and social care sector to be included in the search (see appendix 2).

Racial discrimination

In social science, this includes two components: 1- differential treatment based on race that disadvantage a racial group and 2- a differential effect related to treatment based on inadequately justified factors other than race that disadvantages a racial group. The EHRC defines racial discrimination as incidents ‘when an individual is treated differently because of an individual’s race in one of the situations covered by the Equality Act’. This could be a ‘one-off’ situation or as a result of a policy/systematic treatment based on race.

Institutional and structural racism

The collective institutional failure ‘to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. This can be seen or detected in processes, attitudes, and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantages people in ethnic minority groups’ (Macpherson, 1999).

Structural racism refers to wider political and social disadvantages of groups with certain characteristics in society. In other words structural racism normalises historical, societal and institutional practices that disadvantage people with different characteristics, including people in ethnic minority groups.

Workplace/labour market inequalities

Workplace inequalities can be evident through a variety of indicators; this review aimed to identify experience and inequity in relation to the following:

Sorting and employment segregation: 'the index of dissimilarity' (Reskin and Roos, 2009) health and social care includes significantly larger proportions of women and workers with migrant backgrounds than other industries. Thus, we are already focusing on some of the higher segregated occupations. However, one of the 'outcomes' of this review will consider the over-representation of different groups of ethnic minorities.

Earnings: The review focuses on low-paid workers only and might not capture wage-inequalities. However, publications focused on earnings and wage inequalities will be included.

Job and contract security: including awareness, availability and access to different employment rights.

Scheduling and task assignment: if work scheduling is differential in sorting of workers by race/ethnicity, not just by occupation. Similar sorting can be found in relation to assignments to 'complex', 'high need' or 'challenging' service users/patients.

Workplace experience: reports of bullying, feelings of exclusion, stress, intention to quit, mistreatment, job and employment satisfaction, work-life balance, and other aspects of job quality. Given that we are focusing on a group of occupations unlikely to exhibit further wage-differentials, this review is likely to capture inequalities related to workplace experiences.

Ethnic minority groups

Ethnicity is not fixed or easily measured, and it differs from race, nationality, religion, and migrant status. Other social markers/social experience might further identify a minority group such as White Muslim women, White traveller communities, or White European migrants (through the use of language and accent). Concepts of race, emphasis its social origins rather than its biological basis. In the literature, minority ethnic/race usually provides a way to define groups that look different and/or have separate ancestral roots. For this review, we have included various terms to identify self-defined ethnicity, migration status and other minority groups such as religious and traveller groups.

Scope

The review covers Great Britain – most of the UK, including England, Wales and Scotland, but excludes Northern Ireland – and focuses on recent evidence since 2017. The review was primarily focused on low-paid jobs in the health and social care sectors with attention to analysing the impact of ethnicity or belonging to a minority group. It also captured literature that focused on health or social care as employment sector but with a broader focus on different job roles and occupations, including some defined as low-paid. It also included literature with interest in a range of low paying sectors as long as either health and/or social care jobs were in the scope of such publications. Details on the specific population group, time frame and restrictions are provided below.

Population group

Sector: Low paid workers in health and social care: NHS; Adult social care.

Condition: Around £10 per hours to include direct care, administration and ancillary jobs.

Characteristics: Ethnic minority groups.

Time frame

Recent evidence since 2017. Exceptions for including publications from an earlier date would relate to important studies, with clear justifications for inclusion. Key authors were identified and contacted to capture ongoing research and early findings, especially in relation to the impact of COVID-19. A minimal number of publications prior to 2017 were included to reflect seminal work related to ethnicity and low pay in adult social care.

Restrictions

Great Britain only (including England, Scotland and Wales; excluding Northern Ireland). Publications in the English language only.

Search and retrieval strategy

To address the full range of the research questions, the review had three search stages. The first identified evidence on differential work experience and outcomes by ethnicity (in its broadest definition as discussed earlier) in the health and care sector, particularly among low-paid jobs. The second focused on evidence that examines the association between structural racism and discrimination and their role in explaining differential experiences. The third search will focus on evidence related to the impact of COVID-19 on various work outcomes and ethnicity.

A search strategy was developed and modified iteratively for the three stages of searches. The overall search statement identified the Population (P); Intervention (I) and Outcome (O):

(P) ('health and social care sectors; separated by OR' AND 'identifiers of low paid jobs separated by or' AND 'identifiers of race/ethnic minorities; separated with OR') AND (I) ('identifiers of workplace treatment separated by OR') AND (O) (identifiers of work outcomes separated by OR). For full details, see appendix 3.

Searches were conducted iteratively with the following step process: P AND I; P AND O; P AND I AND O; further searches with sub-P. All results were combined before the screening and assessment process. The searches were completed in December 2020.

A separate search strategy was devised for the additional research question concerned with identifying case studies of interventions to reduce racial inequalities in the health and social care workplaces, particularly for low-paid occupations. An additional review scope, specific to identifying interventions, was conducted in January 2021.

The following databases were searched: Web of Knowledge, Nursing Index; CINAHL; EBSCO; ERIC; Social Care Online, SCIE, Google Scholar; NHS Evidence; Nursing@OVID; Medline; Pubmed and Scopus.

Grey literature was not included, although some exceptions were made for reasonably robust analyses of the COVID-19 pandemic's impact, given the fast-moving situation and rapid turnaround of research into the effects of the pandemic.

References of all identified publications for inclusion were hand-searched for additional relevant outputs. Furthermore, all publications citing identified publications were scanned for relevance. Furthermore, a call for evidence was posted on social media and by direct emails to expert networks to capture ongoing relevant research.

Appendix 2: Low-paying job titles in health and social care in Britain

Job title	Hourly pay
Health care assistant	£9
Health advisor/ NHS 111	£9–£12
Care assistant	£9–£16
Home care worker	£8–£10
Support worker	£9
Complex care worker	£9–£12
Mental health care worker	£11
Care worker	£9–£15
Relief worker	£9–£12
NHS admin	£9–£12
Personal assistant	£9–£10
Residential care officer	£10–£15

Job title	Hourly pay
Medical workforce coordinator	£10–£13
Domiciliary care worker	£9
Community care worker	£10–£13
Home care assistant	£10–£20
Home support care assistant	£8–£10
Cleaner	£8–£10
Caretaker	£9
Support worker car driver	£8–£10

Appendix 3: Search terms

Population (P):

Sector: NHS, Health, Social Care, care work, adult social care:

NHS, care home*, residential care, domiciliary care, home care, hospital, community health, long term care, LTC, care service*, dementia care, Alzheimer care, palliative, hospice, children services, social services, health care, clinic, GP, general practice, nursing home*, community care,

AND

Low paid jobs:

low-paid, low-pay, low pay, allied health professional*, careg*, carer*, fronline, ancil*, [PLUS: terms for individual jobs/groups (see excel sheet)]

AND

Minority ethnic groups:

Black, Asia*, Chine*, Mixed, Afr*, BME, BEME, minority, native, White, Irish, social mark*, colo*, ethni*, migr*, rac*, Immig*, Bangal*, Pakist*, Caribb*, India*, accent, Hind*, Muslim, Islam, Christ*, Sikh*, travel*, gyps*, refuge*, asylum, non-European, East Europ*, Pol*, visible mark*

Intervention (I):

Workplace treatment:

contr*, access, treat*, discrim*, work inequ*, bully*, working hours, sick pay, absen*, racism, equali*, support, work polic*, part-time, part time, flexib*, work schedul*, temp*, job security, job quality, on call, on-call, bias, precar*, workload, task allocat*, shift*, roster*, challeng*, prejudice, preferential, differential treat*, inequal*, equip*, information, exploit*, employment right*, statutory, allocate*, train*, complain*, discrim*, mistreat*, abuse, harass*, victim*

Outcome (O):

wage*, earn*, job sat*, stress, burnout, work-life, progress*, promot*, satis*, wellbeing, wellbeing, health, quit*, dispute, tribunal

Overall search statement

(P) (‘identifiers of health and social care occupations; separated by or’ AND ‘identifiers of low paid jobs separated by or’ AND ‘identifiers of race/ethnic minorities; separated with OR’) AND (I) (‘identifiers of workplace treatment separated by OR’) AND (O) (identifiers of work outcomes separated by OR)

Contacts

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