JRF programme paper:
Poverty and ethnicity

Poverty, ethnicity and caring

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This paper:

- considers the extent to which ethnicity is a factor in the ways in which families structure care of children and of disabled adults;
- analyses how the resulting choices and opportunities influence and are influenced by poverty; and
- explores how these relationships may vary over time and across different ethnic groups.

The Joseph Rowntree Foundation (JRF) commissioned this paper as part of its programme on poverty and ethnicity which aims to understand the underlying reasons for variations in low income and deprivation among different ethnic groups in the UK and the problems caused. It also aims to contribute towards solutions to these problems.

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This paper was commissioned to inform the work of the JRF poverty and ethnicity programme, which aims to understand the underlying reasons for variations in low income and deprivation among different ethnic groups in the UK and the problems caused. It also aims to contribute towards solutions to these problems.

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

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Introduction

Family responsibilities and economic outcomes interact in complex ways. In Britain today, most unpaid care, both of dependent children and frail or disabled adults, continues to be provided by women. Yet two in three women are in paid work, up from just over half a generation ago (ONS, 2010a) and one in four children grow up with only one parent (DWP, 2010, Table 4.3). This creates new pressures on the supply side of the caring equation. On the demand side, as people live longer lives, with lengthening periods of ill-health and incapacity at the end of them, the overall pressure on carers has grown.

These overall trends raise the issue of how families can both earn enough to escape poverty and ensure that family members are properly cared for. Potential carers may need to work in order to lift family incomes above the poverty line. In 90 per cent of non-pensioner families in poverty, there is either no full-time worker or at least one person not working at all. In only six per cent of families in poverty do all adults work full time (calculation from HBAI 2008/9, Table 3.3. DWP, 2010) Self-employed people and families with at least one member over 60 are excluded from the calculation). Economic inactivity is sometimes voluntary, but often not: more than one in four women who do not work would like to do so. (Grant and Buckner, 2006, pp.1.) While constraints that prevent women from working are multiple and often complex, caring responsibilities can play an important part.

Differences in the situation of different ethnic groups can be important in this picture for several reasons:

- There are wide variations in overall employment rates and in women's employment rates across ethnic groups. Various factors may influence this including ethnic differences in education levels, occupational patterns and choices about work and family care.
- Different ethnic groups may have different attitudes towards paid work, unpaid caring and using paid-for care services (e.g. domiciliary care, childcare).
- Different ethnic communities may have different resources in terms of the availability of unpaid care through extended families, friends and neighbours.
- A number of barriers may prevent members of various ethnic groups from accessing paid-for care services, including cultural sensitivities that are not fully addressed by these services and a lack of information and networks that enable groups to access these services.

The box below gives a brief overview of who provides unpaid care in the UK, in relation to who works. In this paper, we look at two broad groups (which overlap) – those caring for people because they are disabled, frail or sick and those caring for dependent children. (Within these groups there is considerable heterogeneity which we have not been able to capture in this brief paper, including, for example, the huge pressures on families that care for disabled children.)

Who cares: an overview

Caring for sick, disabled or frail people

Estimates by Carers UK, www.carersuk.org/Newsandcampaigns/Media/Factsaboutcaring

Number of carers: Six million (one in eight adults)
Trend: Projected rise to nine million by 2037
Gender balance: 58 per cent female. Female carers care for longer hours on average
Highest by age/gender: Women aged 50–59 (one in four are carers)
Highest by ethnicity: Pakistani and Bangladeshi (three times as likely as white British)
Relationship with working: 2 million full-time; 1 million part-time; 3 million not working. Average earnings loss resulting from reduced hours or not working: £11,000.

Caring for dependent children

Economic inactivity rates aged 25–34: men 7 per cent, women 14 per cent (ONS, 2010b, Table 2.12)
Economically inactive because looking after family/home: men 116,000, women 1,558,000 (ONS, 2010b, Table 2.14)
Economic activity rates by ethnicity: 32 per cent of people from ethnic minority backgrounds, 21 per cent of general population
Highest inactivity rate by ethnicity and gender: Two-thirds of Bangladeshi women, more than half of whom are taking care of family and home (www.emetaskforce.gov.uk/keys.asp).

These data show that among both of these groups, women provide considerably more care than men. It would, however, be wrong to overlook men's contribution to caring. For example, one in six men aged 45–59 is a carer, and one in four of these care for at least 20 hours a week.

Poverty and caring: choices and constraints

The relationship between poverty and caring can be seen both in terms of the choices that people take and the possibilities open to them. Individuals make trade-offs between time spent earning and caring according partly to their preferences and interpretation of their family obligations. For example, those who attach a strong importance to family care-giving may be more likely to accept a relatively low income and a degree of economic hardship as a result of caring, even if using formal care services may result in higher net family income. Evidence points to differences across groups in such attitudes. For example, one qualitative study found that a concept of care-giving as 'natural, expected and virtuous' was prevalent among South Asian but not white British participants, with black Caribbeans more divided in their attitude (Lawrence, *et al.,* 2008).

However, the context of applying any given set of preferences will in practice vary greatly across families according to their circumstances. Many families on lower incomes have less control and choice in their lives than more advantaged families. For example:

- available work options may be too poorly paid to make it economical to pay for formal care arrangements of sufficient quality (Grant, *et al*., 2006; Escott and Buckner, 2006; Dex and Ward, 2007);
- choice over hours and flexibility of job arrangements may be limited in relation to managing care (Grant, *et al*., 2006; Escott and Buckner, 2006; Dex and Ward, 2007)
- the local supply of caring arrangements may be inadequate in terms of quality and flexibility (Stanley, I., 2006; Unison, 2006);
- individuals may have inadequate information about the options available (Barnabas, 2005; Patel and Kelley, 2006).

These factors help explain, for example, why families on lower incomes make much less use of formal childcare arrangements when they do work (Grant, *et al*., 2006; Escott and Buckner, 2006; Dex and Ward, 2007; Stanley, *et al.,* 2006; Unison, 2006; Barnabas, 2005; Patel and Kelley, 2006) and why many families in poverty are deterred from working due to limitations in available formal childcare opportunities (Waldfogel and Garnham, 2008).

Another important consideration is the availability of support networks within one's family and community. A stereotype here is that people in poorer communities and in certain ethnic minority groups have stronger support networks, because extended families live closer together and communities are more close-knit. As will be shown later, however, the reality is highly variable, and for many families facing disadvantage, especially recently arrived migrant groups, a lack of 'social capital' is a crucial constraint.

Overall, these factors are part of the 'capabilities', identified by Sen (1980), as defining people's ability to enjoy fulfilling lives. Insofar as poverty constitutes a combination of constraints that limit such capabilities, some families can get trapped in a cycle whereby caring limits their ability to work and progress in the labour

market. This in turn constrains their ability to develop social capital, skills and other resources that might contribute to better choices in reconciling earning and caring. The intertwining of caring and employment may restrict the extent to which women can progress their careers. At one extreme, caring responsibilities can preclude any form of employment (Dale, *et al*., 2002). For some others, work-life balance can only be achieved through part-time and/or low paid work (Grant, *et al.,* 2006; Escott and Buckner, 2006; Dex and Ward, 2007) or by taking less demanding jobs, for which they are often over-qualified (Botcherby, 2006; Liversage, 2009). At the other extreme, there are women with readily available sources of childcare support within the immediate and extended family that enable them to work full-time (Clark and Drinkwater, 2007).

The ethnic dimension

To what extent do these relationships between poverty and caring vary for people of different ethnicities? This raises questions about whether ethnicity itself influences caring norms, but also about how ethnicity interacts with other factors including poverty, demographic characteristics, skills and various forms of discrimination to influence caring outcomes.

As a start, some simple facts about certain ethnic groups seem to suggest that choices and constraints produce different outcomes for people from different ethnic backgrounds. In particular, in Bangladeshi and Pakistani families, only one-third of women work, compared to the two-thirds of women who work overall (Labour Force Survey, second quarter 2010, data supplied by DWP). The size of families tends to be larger (South Asian families will continue to be larger than British families but the gap will decline over time as fertility rates for the former decline (Markkanen, *et al.,* 2008)). South Asian mothers tend to have children earlier, although more South Asian women are starting to delay having children in favour of their careers (Aston, *et al*., 2007; Markkanen, *et al*., 2008). They remain likely to get married earlier (Markkanen, *et al*., 2008), and a higher proportion of older people are in ill-health (Salway, *et al.,* 2007). The use of professional carers is much lower both in terms of childcare and adult care than for the white population and for most other ethnic minority groups (Strategy Unit, 2003; Aston, *et al.,* 2007).

This suggests that there are at least some ethnic minority communities whose living patterns, values and opportunities cause many women to spend significant periods of their lives focusing on housework and caring for younger and older dependents, with limited participation in the labour market. For some this is a voluntary choice; for others a product of limited alternatives. These low economic activity rates contribute to high poverty rates among families in these ethnic communities. [1] Cultural barriers to using paid-for care services may contribute to this phenomenon.

What is harder to make generalisations about is the extent to which these ethnic differences derive from ‘cultural’ differences in attitudes towards care or from differences in opportunities and constraints. We must certainly take care not to develop stereotypes such as ‘members of ethnic minorities live in closer-knit communities where families prefer to look after their own’. For a start, we must note that experiences are diverse.

- There are big differences across the main ethnic minorities in their patterns of care use. For example, African Caribbean mothers are more, rather than less, likely to use formal childcare (Bell, *et al*., 2005; Stanley, *et al.,* 2006 Dex and Ward, 2007).
- There are big differences across and within ethnic groups in terms of the types of support networks available within communities. In particular, there is a large gap between the situation of settled ethnic communities with strong structures for family support and recently arrived migrants isolated from the communities around them. A study of the interface of Sikhs with dementia care in Wolverhampton showed that, even within a particular ethnic group,

variations in practice and attitude can vary greatly according to the particular characteristics including migration histories of different members of one group (Jutlla and Moreland, 2009).

- There is no general evidence of cultural resistance to the use of paid care by ethnic minority or ethnic groups: cultural barriers, where they exist, appear to concern specific cases in which users fear that services will be culturally insensitive (for example, by not taking account of religious values or linguistic differences), rather than on principled objections to using such a service (Manthorpe, *et al*., 2008).
- There are important differences between geographical areas in terms of the ethnic patterns of settlement, their employment patterns, and the distribution and quality of health and care services that they have to draw on (Buckner and Yeandle, 2006).

In this regard, the remainder of this paper discusses the diverse experiences of different ethnic groups with reference to existing evidence, and then goes on to suggest how new research and analysis might approach the issues raised by this evidence.

How much unpaid care? Caring need and the use of formal services

The amount of unpaid care provided by members of different ethnic groups is influenced by the number of people requiring care, the level of their care needs and the rate at which groups use unpaid services.

Most obviously, demand for the care of children is influenced by the number of children in the family. Care for elders is influenced by the number of adults in poor health or with disabilities. Bangladeshi and Pakistani families tend to be larger and start younger. Poorer health outcomes among older Bangladeshis in particular also increase the pressure on elder care. Census data shows that the rate of limiting long-standing illness is about 50 per cent higher for Pakistani and Bangladeshi women than for the white population, and somewhat above average for most other ethnic minority groups but lower among the Chinese population (Butt, 2007). Among many newer economic migrants, relatively fewer dependents are in the UK, with older generations and sometimes dependent children are still in the country of origin.

When thinking of all these demographic factors, we need always to be aware that we are looking at a moving picture. The average number of children in South Asian families in Britain is declining (Markkanen, *et al.,* 2008). Conversely, the number of elderly people among many immigrant communities that in the past have had an atypically young demographic profile is rising. In 2001, 38 per cent of Bangladeshis in the UK were under 16 and just three per cent over 65; for black Africans, it was 30 per cent and two per cent respectively (Dobbs, *et al.,* 2006). An example of how greatly this will change can be seen in a projection of the demographic composition of Birmingham. This estimates that between 2001 and 2026, the number of Bangladeshis over 65 will almost triple, the number of Africans over 65 will rise by five times but the number of whites over 65 will decline. As a result, the proportion of the over-65 population from ethnic minorities in Birmingham will double from one in eight to one in four (Simpson, 2007).

These demographic changes will cause a shift in care demand among such groups in the coming years, from dependent children to older adults, in a way that accentuates the overall trend in that direction in the UK: as settled populations shift in their profile towards the present situation in the UK as a whole (where there are as many pensioners as under-16s), elder care will become far more significant relative to child care.

The amount of care that falls on informal carers in different ethnic groups depends also on the extent that they make use of formal carers. In the case of both children's and older people's care, this varies greatly by ethnic group. This is due not just to the different rates at which people with dependent children or others needing care go out to work, but also the likelihood of using formal care when they are working. For example, one survey showed that 47 per cent of white children and 57 per cent of black Caribbean children under 14 had used formal childcare some time in the past year, but the figure was much lower for Bangladeshis (24 per cent), black Africans

(36 per cent), Indians (28 per cent) and Pakistanis (20 per cent) (Bell, *et al,* 2005*,* Table 5.1).

The extent to which families use paid and unpaid care services is clearly influenced by different ways in which families live. A clear-cut explanation for the relatively high overall rate of childcare use among African Caribbean compared to South Asian families is that many more of the former – 48 per cent of households with children (Dex and Ward, 2007) – are lone parents, for whom the only route out of benefit dependency and poverty is to work and use formal childcare. Another influence is the availability of free non-parental care within extended families: 57 per cent of South Asian families use grandparents to care for their children compared to 45 per cent of white families (Dex and Ward, 2007). In cases where a grandparent looks after a child when a parent goes out to work, the use of informal rather than formal childcare can have different effects on a family's risk of poverty, according to circumstances. In the many cases where the grandparent would not have been in paid work, this arrangement will help the family raise their income without the offsetting cost of childcare. On the other hand, where the grandparent gives up a job to look after a child, the net income of the extended family may suffer more than if it had used formal childcare. This will depend on the number of children being looked after and the earning power of the grandparent, but an unfavourable factor in this scenario is the fact that the cost of formal but not informal childcare can be supported by tax credits. A related factor is the barriers faced by some members of ethnic minorities in taking up tax credits, related either to issue of language, knowledge of the system and in some cases concerns about residency status (Platt, 2007).

Who is available? Issues of networks, roles and attitudes

Decisions about the role of unpaid care by family members in looking after a dependent child or an adult requiring care are influenced by a complex set of considerations. Two crucial factors that vary across and within ethnic groups are the attitudes of family members to what kind of care is appropriate and the availability of networks within families and across communities.

Existing research confirms that groups that use formal care services the least do so partly because they do not want to leave their children with non-family members (Bell and Casebourne, 2008), and are also reluctant to have strangers helping to look after elderly relations. For South Asian families, this ties in with traditional attitudes that view women more as carers rather than as earners) Yeandle, *et al*., 2006; Aston, *et al.,* 2007; Tackey, *et al*., 2006; Dale, *et al.,* 2002). However, British-born Asian women today tend to have much stronger career ambitions than their mothers (Aston, *et al*., 2007). In light of the competing pressures on this group of women in particular, the objective of developing models of work that are compatible with family responsibilities will be particularly important in the future.

Within each community, different families have different levels of resources to draw on, in terms of support networks within and outside the family. Black and white mothers who are in work are more likely to use formal childcare than Pakistani or Bangladeshi working mothers, who rely far more heavily on grandparent care (Strategy Unit, 2003; Dex and Ward, 2007). However, quantitative analysis of survey data shows that in ethnic minority communities, while extended family care within households is more common, cross-household care (i.e. people looking after friends, relatives or neighbours living in different households) is relatively less so (Hutton and Hirst, 2000). In this context, care issues can be difficult for individuals in communities where extended family support is seen as a norm, but where that support is not always, in practice, available. For example, an elderly person living on their own, without children living nearby may experience difficulties in a community where most people rely on their families to support them.

Research has demonstrated how, within any given ethnic group, specific circumstances can play out differently. This was looked at in detail in the study, referred to above, of Sikhs as carers for people with dementia. This study demonstrates how even among settled immigrants, differing life experiences can produce varied outcomes. To illustrate this, it gives one example of a Sikh woman with very limited language skills who travelled to England relatively recently with her mother-in-law whom she cares for, and who faces extreme isolation and a lack of support networks. This contrasts with another example of an older Sikh man looking after his wife, whose different caste, migration experience, language skills and life experiences give him a very different experience as a carer. These examples illustrate the multiple factors at work in shaping care experiences(Juttla and Moreland, 2009),

Accessing informal sources of care can be also be problematic for some groups of recent migrants, who lack the readily available social networks to achieve this (Katbamna, *et al.,* 2004). Much depends on whether people move into communities of mutually supporting fellow nationals or into more isolated situations. Important issues of information and cultural barriers also arise. One recent report, for example, highlights issues facing the Nepalese community, including Gurkhas, many of whom face isolation, with limited knowledge of English and a lack of knowledge of local services (Sims, 2008a). A set of Runnymede reports describes the very particular experiences of different groups, such as Moroccan, Thais and Cameroonian migrants (Cherti, 2009; Sims, 2008b; Sveinsson, 2007). Another report in the same series points to how Thai women married to White British men often face isolation because of a lack of social networks (Sims, 2008b).

Due to the provisions of the 1999 Immigration and Asylum Act, the latter situation is one that faces many new migrants. The dispersal policies inherent in the Act aims to house new migrants among existing minority communities, but often means that new migrants are settled in areas with an abundance of cheap housing and with limited experience of immigration (Moran, 2006; Spicer, 2008). Their isolation, through limited welfare and employment rights, makes it more difficult to form the social networks necessary to find out more about the availability of care.

Access to appropriate formal care services

Minority ethnic groups who make relatively low use of formal care services have been found in some research to express two types of objection to doing so:

- Because they feel uncomfortable about having a family member being looked after by professionals rather than by people who know them (Bell and Casebourne, 2008). This expresses a traditional attitude about the roles that families should play in care.
- Because they feel that the care services provided will not be culturally appropriate (Stanley, *et al*., 2006; Pascal and Bertram, 2004; Craig, *et al*., 2007). This expresses a reservation about the nature of the actual services available, rather than a more generalised view about using such a service. It can be reinforced by a lack of good information about available services (see for example Blood and Bamford, 2010, which emphasises lack of information and understanding as a barrier.).

To some extent, the first of these attitudes should be accepted as a legitimate viewpoint reflecting the values of particular communities. Even so, it would be foolish to regard it in any way as an 'absolute' perspective. In practice, there will be circumstances in every community where professional interventions are unavoidable, for example where a parent has no economic alternative but to work, or where an older person's condition is impossible to deal with at home. People who feel that care is the role of the family often feel that this is a sign that they have 'failed' the individual being cared for (Jutlla and Moreland, 2009), but their actual experiences of the quality of care is likely in these cases to influence this attitude.

In the second case, however, there is much debate about how to provide formal care services, especially for older people, that are culturally sensitive. Despite some research appearing to show that some users favour separate services such as Asian care homes (Jolley, *et al.,* 2009), more generally the evidence seems to show that the main obstacle here is cultural insensitivity, or the fear of it, rather than a general objection to being cared for by or with people from different backgrounds (Boneham, *et al*., 1997 and Manthorpe, *et al*., 2008). In any case, care services are themselves increasingly staffed by members of ethnic minority groups, especially in London (Canganio, *et al*., 2009), although this would not prevent some people from both ethnic minority and white populations potentially having reservations about being looked after by people from different backgrounds to themselves.

In principle, current policies seeking to create greater personalisation and choice of care services should help users feel more in control of the type of care that they receive, and create a better fit between cultural preferences and the type of service delivered. However, this depends both on market responses to such initiatives and to user information. An important feature of these policies is therefore the extent to which users are given good information and advice about what services are on offer.

Caring, earning and the labour market: opposing pressures, different outcomes

A wide-ranging study of BME women's position in local labour markets has concluded:

> *Women from black and minority ethnic groups often face particular difficulty in accessing employment or in securing work positions which match their skills, talents and abilities. These difficulties may be caused by: socio-economic disadvantage in the localities in which they live; discrimination and social exclusion; poor recognition/acceptance of the skills and qualifications they possess; inadequate support for their family and caring roles; and limited opportunities to gain skills relevant to their employment, such as fluency in English. (*Yeandle, *et al*., 2006)

For different families, these disadvantages can lead to very different results. For some, it leads to exclusion from the workforce and the entrenchment of family poverty. For others, it leads to long hours to make ends meet on low earnings, supported by childcare arrangements. In between these extremes are those who 'juggle', working part-time sometimes with more impromptu or informal childcare arrangements, in some cases still facing poverty.

While it is hard to generalise how these patterns work out for different ethnic groups, there is certainly a tendency for South Asians to be in the first of them, while African Caribbeans tend to be in the working categories. Recent economic migrants are often in the working group, tending to prioritise earning even where this can cause serious family disruptions and care arrangements that they find unsatisfactory . For example, Sims, (2008b), discusses the challenges faced by Thai parents working long hours in restaurants. On the other hand, only 29 per cent of refugees, the great majority of whom are from ethnic minorities – more than 90 per cent of asylum seekers are of Asian or African origin (ONS, 2009, pp.11) were in work, compared to 60 per cent of all members of ethnic minority groups (Bloch, 2002). If they do work, then initially at least, it is likely that refugees will find work that is low-skilled, low-paid and perhaps part-time. This limits the extent to which work can lift them and their families out of poverty (Patel and Kelley, 2006). The Points Based System (PBS), the centrepiece of the recent immigration policy, arguably de-skills immigrants by pushing them into work for which they are overqualified. This is as a result of the narrow formalism of the PBS which ignores the fact that a wide range of professions and jobs require a combination of general educational qualifications, work experience and the presence of soft skills of various types. Many of these factors are ignored, which allows some relatively well-educated migrants to be able to access only lower-level jobs with more specific skill requirements (Sveinsson, 2010).

Some refugees prioritise often low-skilled, low-paid work to provide for their family ahead of learning English (Steels and England, 2004). Language can be a considerable barrier for some refugees in accessing childcare. They then face the

Catch-22 situation of being unable to attend English classes because they have nowhere to leave their children (Tyler, 2010).

Issues for research and analysis

As a first step to understanding the relationship between caring, earning and poverty among different ethnic groups, we need information about different and changing patterns of care needs and formal and informal care provision. At present, while some general information is available for the larger ethnic groups, much less is known about smaller ones, especially more recent migrants. Both for newer arrivals and for settled groups whose populations are ageing and family structures changing, detailed demographic analysis broken down by ethnic group would help to identify the extent to which the supply of available informal care will be able to match future demand under existing patterns of caring. The impact of dispersal policies on caring networks and patterns for new migrants could be part of this, and the new immigration cap could impact on the supply of care.

In producing such an understanding, we need to be careful not to make simplistic assumptions about the availability and desire of members of various ethnic minorities to provide care within the family. In order for services to be well targeted, there is a need to understand both variability and changes in such attitudes within each ethnic group. These attitudes will interact over time with:

- changing perceptions of the acceptability of formal services and the feasibility of combining work and care with some paid-for support;
- generational changes, with different aspirations developing among the children of migrants, both in terms of economic welfare and use of rising qualifications in the workplace;
- related changes in labour market opportunities. In particular, Pakistani and Bangladeshi women, who of all ethnic groups have had the lowest participation at work, now have much greater opportunities to do well because their educational qualifications have risen rapidly;
- influences on family and community networks, including pressures on older people to continue working for longer and a growing demographic pressure in ageing populations that could stretch family caring resources.

In this context, research and analysis could be oriented not to producing generalised comparisons of the ‘average’ attitudes and situations of different groups, but could explore diversity within groups and in particular how these things are evolving, along with the patterns of living of various ethnic communities. Ultimately, it should explore how the ‘capabilities’ of families in these communities to achieve their goals with respect to earning and caring, are developing over time.

These patterns should also be considered in relation to the services available in each community. Given that it does not appear from the existing evidence that whole ethnic groups have generalised objections to using care services, the focus here could be on ‘what works’ to improve sensitivity of services, quality of information and a better understanding among potential clients of what care services can offer.

Government pilot schemes relating to outreach have already uncovered some potentially innovative techniques which could be used to improve access to mainstream services for some hard-to-reach ethnic groups.

Another part of the context that continues to evolve is labour market opportunities, and in particular those facing women who need to juggle earning and caring priorities. There is plenty of general research on this theme, including on some of the larger, more settled minority ethnic groups. However, given the recent waves of immigration among groups from a wide range of countries and cultures, there is a particular need for more information about how these groups are balancing their domestic and working lives.

Conclusion: looking across situation, place and time

This paper has argued that while there are many ways in which the challenges of reconciling care responsibilities with escaping from poverty can be particularly relevant for members of ethnic minorities, generalisations can be risky. The closer researchers have looked at the situations of families, even within particular ethnic minority groups, the more they have seen that not everybody conforms to a particular cultural or economic norm associated with each group.

A productive way of taking forward work on this topic may be to consider how the context of caring among ethnic minorities is being affected by particular situations and conditions, and how it is changing across time. For example, studies of these issues in particular places (Yeandle, *et al.,* 2006) have found varying rates of caring, in different locations. More detailed study is needed to understand better how these experiences among particular ethnic groups are impacted by the particular conditions of where people live, such as the quality of available services.

The time dimension is crucial, suggesting a 'dynamic' approach to this topic. To what extent do the attitudes and practices of various groups change over time? This question applies both to newly arrived migrants and to more settled ethnic minorities whose age profile is changing and for whom attitudes in the second generation of migration differ from those in the first. Another key dynamic factor concerns experiences of service: to what extent can good quality and culturally sensitive services influence the acceptability of paid-for care and hence widen the options available to those who wish to balance caring and earning priorities?

This paper has not been structured around 'inter-sectionalities' between ethnicity and other family characteristics. This is partly because of severe limits in evidence broken down in this way, and partly because the most important demographic characteristic affecting caring responsibilities – gender – is an integral part of the story. However, the above analysis has suggested three variables that could be investigated further: place, age and cohort. The last two of these are related but distinguishable factors, describing respectively the attitudes and practices of people towards caring at different ages and the ways in which successive generations within each ethnic group responds to parenting and to elder care. As the family life and economic fortunes of different ethnic groups evolve, an understanding of such changes will be essential to future strategies to address poverty.

Notes

1 The latest HBAI survey (DWP, 2010) shows that in 2008/9, 81 per cent of Pakistanis and Bangladeshis and 52 per cent of Black Caribbean's were in the bottom two quintiles of the income distribution (after housing costs), according to the Family Resources Survey 2007 (Table 3.1). 60 per cent of Pakistanis and Bangladeshis had incomes of below 60 per cent of median incomes (after housing costs), while the corresponding figure for black Caribbean's was 32 per cent (Table 3.5).

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