SOCIUM · SFB 1342
WorkingPapers No. 11

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Migrantization of long-term care provision in Europe

A comparative analysis of Germany, Italy, Sweden, and Poland

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Globale
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SFB 1342

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SOCIUM SFB 1342 WorkingPapers, 11
Bremen: SOCIUM, SFB 1342, 2021

Universität Bremen

SOCIUM Forschungszentrum Ungleichheit und Sozialpolitik /
Research Center on Inequality and Social Policy
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CRC 1342 Global Dynamics of Social Policy

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Websites:
https://www.socium.uni-bremen.de
https://www.socialpolicydynamics.de

[DOI: https://doi.org/10.26092/elib/3502]

[ISSN (Print) 2629-5733]
[ISSN (Online) 2629-5741]

Gefördert durch die Deutsche Forschungsgemeinschaft (DFG)
Projektnummer 374666841 – SFB 1342

DFG Deutsche Forschungsgemeinschaft

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Acknowledgements:

Funded by the Deutsche Forschungsgemeinschaft (DFG, German Research Foundation) – Projektnummer 374666841– SFB 1342.

Abstract

Since the 1990s, many countries in the world have been experiencing a process of migrantization of the long-term care workforce, defined as the incorporation of migrant workers into formal and/or family care. Previous research has identified two models of migrantization (the migrant-in-the-family model and the migrant-in-formal-care model), depending on migrant carers' working place. However, cross-country variations in the intensity of migrantization and in its loci (in the family, within formal provision or both?) need more thorough investigation.

This working paper describes, compares and explains the migrantization of long-term care in four European countries, representing different welfare state types: Germany, Italy, Poland and Sweden. The findings are based on secondary literature, document analysis, national statistics and expert interviews. The four countries show different patterns of migrantization, that we explain variations in their care, gender, labour and migration regimes. Sweden is characterised by the migrant-in-formal-care model, Italy and Poland by the migrant-in-the-family model, while Germany combines both models. Despite these differences, migrant workers are now needed in all four examined countries. Such transnational care dependencies have to be taken into account when designing and reforming national care, labour market and migration policies.

Zusammenfassung

Seit den 1990er Jahren ist in vielen Ländern der Welt ein Prozess der Migrantisierung der Langzeit-Pflege zu beobachten, der als Eingliederung von Migrant*innen in die formelle und/oder häusliche Pflege definiert werden kann. Bisherige Forschung hat zwei Modelle der Migrantisierung identifiziert (das "Migrant-in-the-family"-Modell und das "Migrant-in-formal-care"-Modell), abhängig vom Arbeitsort der migrantischen Pflegekräfte. Variationen zwischen den Ländern in der Intensität der Migrantisierung sowie Unterschiede in der Einbindung von Migrant*innen in unterschiedliche Formen der Pflegeerbringung (vorwiegend in häusliche oder formelle Pflege oder in beide Formen), bedürfen jedoch einer gründlicheren Untersuchung.

Dieses Arbeitspapier beschreibt, vergleicht und erklärt die Migrantisierung der Langzeitpflege in vier europäischen Ländern, die unterschiedliche Wohlfahrtsstaatstypen repräsentieren: Deutschland, Italien, Polen und Schweden. Die Ergebnisse beruhen auf Sekundärliteratur, Dokumentenanalyse, nationalen Statistiken und Experteninterviews. Die vier Länder zeigen unterschiedliche Muster der Migrantisierung, die wir anhand von Variationen in ihren Pflege-, Geschlechter-, Arbeits- und Migrationsregimen erklären. Schweden ist durch das „Migrant-in-formal-care“-Modell gekennzeichnet, Italien und Polen durch das „Migrant-in-the-family“-Modell, während Deutschland beide Modelle kombiniert. Trotz dieser Unterschiede werden heute in allen vier untersuchten Ländern Migrant*innen in der Pflege benötigt. Solche transnationalen Pflegeabhängigkeiten müssen bei der Gestaltung und Reformierung der nationalen Pflege-, Arbeitsmarkt- und Migrationspolitik berücksichtigt werden.

Contents

1. Introduction

Long-term care (LTC) is a welfare state latecomer (Österle & Rothgang, 2021). Until 1960, only three countries in the world had a long-term care system; by 1965 this number stood at 18, and even today less than one third of all countries in the world, which overwhelmingly belong to the global north, has a LTC system, most of which were introduced after 1990 (Fischer et al., 2021b). Due to demographic change, in these countries the number of care-dependent people has been growing in relation to the number of potential informal care-givers – traditionally predominantly daughters(-in-law) – leading to a shortage of formal and informal care-givers. As this gap has increasingly been closed by migrant care-givers (Da Roit & Weicht, 2013), in most of these countries we now observe what we call a *migrantization* of care-givers, defined as the process of incorporating migrant workers into the group of care-givers. The manifestation of migrantization, however, may differ with respect to the number of migrants, their qualification levels and their working place, i.e. whether they work in formal or informal care settings (van Hooren, 2012). While previous research put forward models to describe different forms of incorporating migrants into the care industry, namely the migrant-in-the-family model and the migrant-in-formal-care model, there still lacks a comprehensive explanation for the variance in the extent of care migration and for the distinct roles migrants play in different destination countries, i.e. the two models of migrantization.

The aim of this contribution, therefore, is to describe and explain the migrantization of long-term care-giving in four countries, namely Germany, Italy, Sweden, and Poland. We have chosen Germany, Italy, and Sweden because they represent three different welfare state types: Germany as a conservative welfare state, Sweden as a social democratic welfare state (Esping-Andersen, 1990) and Italy representing the southern welfare state (Ferrera, 1996).[1] Poland, representing a post-socialist welfare state, has been added, in particular as it is both a source country and a destination country for care migration and thus enables us to study care chains (Yeates, 2012; Palenga-Möllenbeck, 2013).

The causal reconstruction of the migrantization process in these four case studies is based on secondary literature, document analysis, assessment of national statistics and altogether 78 semi-structured expert interviews (Bogner et al., 2009) with politicians and administrators, service providers, unions, and representatives of care-dependent people in the four countries under study. For Germany, additionally, ten problem-centred interviews (Witzel & Reiter, 2012) with migrant care-givers were conducted. Intensive discussions with national researchers were used to prepare the field phase in Italy, Sweden and Poland. All interviews were conducted either in the national language or in English and analysed by content analysis based on deductive and inductive coding.[2] Our explanation rests on the interplay between the respective care regime, general factors pertaining to the national constellation in the source and destination countries such as the labour market and gender regime, as well as transnational factors, e.g. the respective migration regime.

In what follows we will, first, present the theoretical background, i.e. the models we use for the description of migrant care and the explanatory model (Section 2). Based on this, the four case studies (Section 3) provide

1 Though there have been several attempts to classify LTC systems, no typology has found widespread acceptance so far (Fischer et al., 2021a). We therefore refer to welfare state typologies instead.

2 Detailed results of the case studies which link the findings to the respective sources are published elsewhere (Gottschall et al., 2021; Safuta & Noack, 2020; Safuta et al., 2021; Safuta, 2021; Seiffarth, 2021; Storath, 2019). In this contribution we rather use the results of these detailed descriptions.

the empirical material that is then used for the comparative analyses (Section 4) leading to a generalised explanation of the migrantization process. In the conclusion (Section 5) we sum up the main results and discuss the need for future research.

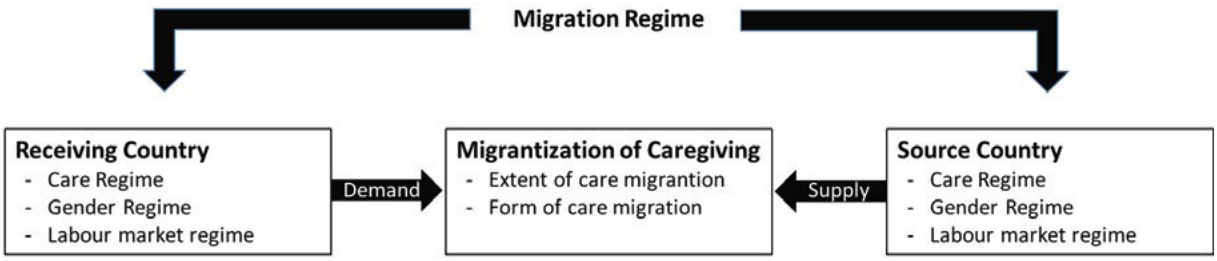
2. Theoretical background

Migrantization can take distinct forms (see e.g. Pries, 2010), reflecting national differences in care, gender, employment, and migration regimes. In the literature two models of migrant care work have been highlighted, depending on the role played by migrant care workers within the overall care system (Bettio et al., 2006; Lightman, 2018; van Hooren, 2012; van Hooren et al., 2018): respite care institutions or formal home care providers. Depending on the deficits in the domestic workforce of receiving countries, immigration may concentrate on highly qualified, well-paid nurses, on less-qualified, poorly paid nurses,[3] or on both.

In order to explain the extent and the form of care migrantization we refer to the characteristics of the receiving and the source countries as well as the migration regime which spans these countries (Figure 1).

On the side of the *receiving country*, apart from an increasing number of people in need of long-term care, three conditions are of major relevance for the demand for migrant care-givers, namely the care, gender and labour market regimes (Kilkey et al., 2010; Lutz, 2011). With respect to the care regime it is important to distinguish whether or not there is a public scheme providing funds for

Figure 1.
Explanatory model



Source: own presentation.

The *migrant-in-the-family model* refers to individuals who live in private households of care-dependent people and provide support for (instrumental) activities of daily living and social care – with or without a formal working contract. From a legal point of view their work must not include medical care, though in reality the demarcation is sometimes blurred. Consequently, in this model a formal training as a nurse is not mandatory for live-in carers (cf. Bettio et al., 2006). The *migrant-in-formal-care* model on the other hand refers to immigration of nurses (with different qualification levels) to work in long-term care facilities, i.e. nursing homes, LTC, and whether these benefits only cover formal care or can also be used for informal care (cf. Ungerson, 2004). The gender and labour market regimes determine the relevance of formal as against informal care, and structure the respective demand for care migration. Moreover, they designate the rel-

3 Lightman (2018, p. 7) recently suggested a *migrant-in-the-middle* model, for systems in which migrant workers "are typically located in low-wage and private-sector care jobs …, but may enjoy greater worker protections". As this is already rather a description of a certain case than a heuristic model it will not guide the subsequent case studies.

ative value of formal care-giving, which in turn has a bearing on whether high or low skilled migrants are sought.

These three regimes are also relevant for the *source countries*. They determine how many (geriatric) nurses have been trained and how many are available, whether they are able to find employment in the domestic care sector and what salaries are paid, particularly in comparison to potential earnings in the countries of destination. The labour market and the gender regimes also shape women's chances of obtaining gainful employment. If employment chances and/or earnings are low in their countries of origin, women may decide rather to work as informal care-givers in destination countries. The mass unemployment that followed the post-1989 socio-economic transformation of former communist Central and Eastern European countries affected women more intensely because of the restructuring of many female-dominated sectors of the labour market such as healthcare (Robert, 2006, pp. 161-163): In line with the neoclassical theory of migration, we assume that (perceived) income differentials between CEE countries and their Western European neighbours also play a crucial role in encouraging migration (Cyrus & Vogel, 2006, p. 81).

Cultural factors such as the preference for family care or a history of domestic servants might increase the chances of a migrant-in-the-family model emerging (cf. Böcker et al., 2017, p. 228). Supply and demand together, however, only lead to significant migration if this is permitted by the respective migration regime.

3. Case studies

Based on this model the case studies below will provide relevant information about the institutional background, describe the extent and form of care migration and analyse the push and pull factors for care migration in the source and destination countries.

3.1 Germany

In Germany, mandatory Long-term Care Insurance (LTCI) for the whole population was introduced in 1995, providing capped or flat-rate benefits to all insured in need of long-term care without means-testing. Care-dependent people may choose between cash allowances, which are free to be spent at the recipients' discretion, and in-kind services (nursing home care as well as home care) (Rothgang, 2010). Following the logic of a conservative welfare and gender regime the entitlement to cash benefits was intended to stabilize the dominant provision of care at home by relatives, which has always been the backbone of long-term care provision in Germany. In-kind benefits for home care aimed at incentivizing the supply of formal home care services, which were very limited at that time, also in order to support family care-givers, while nursing home care benefits were introduced to relieve municipalities from the fiscal burden of social assistance, which they had to grant when nursing home residents were unable or no longer able to finance this type of care themselves (Götze & Rothgang, 2014).

As the ratio of potential family care-givers to care-dependents has decreased over time, and the – still considerable – growth in the workforce of formal care-givers was unable to compensate fully for this, families with care recipients have increasingly responded with the mostly informal employment of Eastern European women, especially in the form of *live-ins* for round-the-clock care (Emunds, 2016; Kniejska, 2016) – which received less political than media attention (Storath, 2019). Their number is now estimated to be up to 500,000 (Benazha & Lutz, 2019), and even around 700,000 (Petermann et al., 2020) if rotation is taken into account, exceeding the size of the care workforce in

home care services, which was 390,000 (in full-time equivalents) in 2017 (Rothgang & Müller, 2019, p. 82). Furthermore, the formal sector, i.e., home care services and nursing home care, has increasingly been recruiting female workers from Eastern Europe (especially Poland and Romania, but also from the third countries Bosnia-Herzegovina and Turkey); their share rose from 6.8 % in 2013 to 13.6 % in 2019, according to a special analysis of official statistics (BA, 2019). In sum, we see a strong (female) migrantization of care-giving simultaneously following routes to both the migrant-in-the-family and the migrant-in-formal-care model. While the former has been widely discussed, the latter has gone almost unnoticed. Interestingly, and in contrast to Lightman's assumption, the migrantization of the formal workforce is focused on highly-skilled (geriatric) nurses, while the domestic supply of less qualified auxiliary nursing staff is still sufficient to cover demand (BA, 2020). However, fluctuation among long-term care workers is relatively high, from the perspective of care workers due to strenuous working conditions, relatively low pay and a lack of public and political acknowledgement of this type of care work (DGB & ver.di, 2018).

Explanations for the growing relevance of both the migrant-in-the-family and the migrant-in-formal-care models of care can be found both on the demand and the supply side.

The *demand* for migrant (geriatric) nurses follows from the deficit in the domestic supply. While the ratio of job-seeking unemployed, qualified geriatric nurses ("Altenpflegefachkräfte") per 100 job vacancies stood at 68 in 2009 (BA, 2020, p. 15), it declined to 45 in 2011 (BA, 2011, p. 6), 38 in 2016 (BA, 2016, p. 14), and 19 in 2019 (BA, 2020, p. 15). Correspondingly, the average time required to fill a vacant post for a qualified geriatric nurse increased from 99 days in 2010 (BA, 2011, p. 6) to 153 days in 2016 (BA, 2016, p. 14) and 205 days at the end of 2019 (BA, 2020, p. 16). Moreover, the current deficit of care workers in formal care is expected to worsen in the coming years (Rothgang et al., 2012). Besides the issue of staff shortages, formal LTC services are rather expensive. As benefits are capped, particularly in nursing home care considerable co-payments are required, which meanwhile exceed 2,100 Euros per month on average (Rothgang & Kalwitzki, 2021). Furthermore, there has always been a societal preference for home care (Meyer, 1996, p. 67; Techniker Krankenkasse, 2018). People in need of long-term care and their relatives particularly appreciate it if care can be provided in their familiar setting by someone with whom they have a personal relationship (Emunds, 2016). Privately hiring a migrant care worker for so-called live-in care has therefore emerged as a highly valued alternative to institutional care (Bettio & Verashchagina, 2012; Böcker et al., 2017). As already mentioned, one feature of the LTCI is cash benefits that are directly paid to care-dependents without much control over what they are spent on. These cash benefits were originally conceived by policymakers as a means of recognising and financially supporting family care (Morel, 2007). Consequently, as female labour market participation has increased considerably (Brenke, 2015) and family structures changed accordingly, cash-for-care subsidies are often used for irregular employment in households. This must be regarded as an unintended, but nevertheless politically tolerated consequence of cash benefits, which were originally aimed at supporting family care-givers (Lutz & Palenga-Möllenbeck, 2010). In effect, the lack of cheap formal care, together with a preference for home care and the opportunity to use cash benefits to finance live-in carers, have created a demand for migrant-in-the-family care.

On the *supply side*, these developments were made possible by the availability of foreign labour. While most migrant care-givers working in German households originate from Central and Eastern Europe (especially

Poland, Romania, Bulgaria and Ukraine), the situation is more diverse in formal care settings. Here, most care migrants come from Bosnia-Herzegovina, Turkey, and Serbia.[4] In former communist countries, the socio-economic transformation of the region following the end of communism caused mass unemployment and a worsening of living and working conditions, which acted as a push factor for migration and drove many people to migrate to Western Europe for higher wages and better working conditions. When moving abroad, these migrants predominantly found work in feminized, undervalued sectors such as care work (Lutz, 2011).

In professional care work, migrants have become a relevant part of the expanding workforce. Their share rose from 6.8 % in 2013 to 13.6 % in 2018 (own calculation based on data of Bundesagentur für Arbeit, 2019. Before 2012, migrants who were already in the country were predominantly recruited by care providers. After 2012 and the change in migration policy, more migrants from third countries took up jobs in formal care settings and care providers started actively recruiting abroad. The share of migrants is higher in auxiliary care positions than in highly skilled positions, however more recent figures suggest that the share of migrants in highly skilled positions is growing, for example from Bosnia-Herzegovina.[4]

While in formal care domestic workers are still predominant, informal care-giving has become a domain of migrant workers, with diverse profiles in terms of age and education. Often, it seems to be women who are already retired in their home countries and have a high school diploma who take up care work in Germany for some additional income (Petermann et al., 2017, p. 14). Before EU accession, these arrangements were mainly brokered by informal networks. With the accession of CEE countries to the European Union in 2004 and 2007, the mode of recruitment changed substantially. Initially, informal private networks facilitated the recruitment of migrant care workers in German households (Böcker et al., 2017). Over time, the number of commercial placement agencies has grown rapidly and they specialize in recruitment from Eastern Europe (Rossow & Leiber, 2017). The transitional provisions for workers from new EU member states that were in place until 2011 (for citizens of A8 countries) and 2014 (for Romanians and Bulgarians) did not halt this development; however, they defined the status of live-in workers as 'self-employed' or posted workers, creating a grey market (Böning & Steffen, 2014). Polish agencies in particular, moreover, apply the Posted Workers Directive to deploy not only Polish but also Ukrainian care workers in Germany. Through the use of these two measures, agencies are thus able to circumvent the social and labour protection standards applicable in Germany, to the detriment of migrant women working in live-in arrangements. Only recently, not least against the backdrop of the contact restrictions and border closures due to the Corona crisis – which has highlighted the extent to which German private households are dependent on this care arrangement (Safuta & Noack, 2020) – have there been cautious signs of a 'normalization' of these employment relationships, flanked by respective policies. For example, according to the draft version of an LTC Reform Act (that had finally not been enacted due to end of the legislative periode), in future up to 40 percent of the in-kind benefits for home care may be used to finance live-ins – conditional on certain criteria such as minimum requirements for qualifications and for brokering agencies, formulated by the federal states (Bundesländer).

The deliberate opening of Germany's *migration regime* has contributed to an increased supply of labour migrants in LTC. Until the early 2000s, Germany did not consider itself a country of immigration, as illustrated by the ban on recruitment from

4 Based on unpublished data that we obtained from the Federal Employment Agency in March 2020.

abroad (Anwerbestopp) in 1973. Later this obstacle to labour immigration was gradually eased in response to labour market shortages. Over time, the ban was suspended for certain occupations and countries of origin, for example the 2002 exceptional provision pertaining to migrant workers from selected CEE countries[5] employed by LTCI beneficiaries as domestic helpers. Similarly, the 2005 Immigration Act (Zuwanderungsgesetz) included a provision for domestic helpers from CEE countries. With complete freedom of movement for citizens of the new EU Member States in 2011 and simplified recognition of educational qualifications, it also became much easier to regularly employ migrants from CEE countries in formal care. In 2013, the labour migration of non-EU nationals was facilitated by an amendment to the Employment Ordinance (Beschäftigungsverordnung). The shortage of skilled care workers had prompted the liberalization of the Employment Ordinance to include professions that require vocational training in Germany (Bonin et al., 2015). Increasingly since the 2010s, geriatric nurses have also been recruited from so-called third countries, made possible by the implementation of the Highly Skilled Workers Directive (Hochqualifiziertenrichtlinie) of 2012 and the Skilled Workers Immigration Act (Fachkräfteeinwanderungsgesetz) of 2020, as well as by bilateral government programmes such as Triple Win, which since 2013 has not only promoted the recruitment of professionals from Bosnia-Herzegovina, Serbia, Tunisia and the Philippines (Bonin et al., 2015), but also since 2019 of those willing to train from Vietnam and Mexico. Moreover, integrating refugees in the care labour market is under discussion as a possible solution to staff shortages (Schmidt, 2019). These changes have also encouraged recruitment agencies to mushroom with their own business models (Kordes et al., 2020). Finally, a separate federal agency was created in 2019/20 for the fast-track recognition of foreign training qualifications in healthcare and nursing. In this respect, the growing presence of almost exclusively female migrants in formal care can be understood as the result of targeted migration and labour market policies, in which actors such as associations of care providers campaigning for easier entry requirements for foreign skilled workers and placement agencies that conduct recruitment and "cultural brokerage" (Pütz et al., 2019) also play an important role.

In parallel, other proactive measures to increase the attractiveness of the sector for local workers can be identified as well: the introduction of a minimum wage for the care industry (2016), the standardization of geriatric and nursing training (Pflegeberufegesetz 2017), changes in staffing levels and funding for additional staff for nursing homes (Pflegepersonal-Stärkungsgesetz 2017, Gesundheitsversorgungs- und Pflegeverbesserungsgesetz 2020), as well as substantial wage increases – though attempts to establish a collective agreement that covers the whole industry failed in March 2021. Migrants in the formal care sector also benefit from these improvements, increasing the strength of the pull factors.

3.2 Italy

Italy has no comprehensive LTC system. Rather, unsuccessful reform attempts due to weak stake-holders and advocates for this policy field, as well as diverging interests across regions (Gori, 2012) signal a 'policy inertia' (Ranci & Pavolini, 2008). Health and social services deliver elder care in a fragmented fashion. Some municipalities did not develop residential and community care services until the 1970s (Costa, 2013, p. 225). Hospitals had been extending hospital stays of older patients to relieve their families (Bettio & Plantenga, 2004, p. 99), but during the 1990s, rationalization and new public

5 Namely Poland, the Czech Republic, Slovenia, Slovakia, and Hungary (Karakayali, 2010).

Table 1.
Long-term care users by sources of public support received in Italy (in %)

Year	Cash-for-care benefit (IA)	Community Care	Residential Care
2000	51	35	14
2010	62	25	13
2015	63	28	9

Source: Gori & Morciano, 2019: Table 2, p. 545.

management in the health sector led to staff and hospital bed shortages and this practice became no longer feasible (Di Rosa et al., 2012). Around the same time, the cash-for-care benefit (*indennitá di accompagnamento*, IA) unexpectedly became the "new pillar of LTC policy" (Le Bihan et al., 2019, p. 591). In 1980, this monthly benefit had been created as an income support for people of working age with disabilities. In 1988, the IA was made available to beneficiaries aged 65 and above, and the numbers of beneficiaries reached a first high in the mid-1990s (Costa, 2013). The share of over-65s that received the IA grew at an annual rate of 8 % in the 1990s, reaching 3 % in the first decade of the 2000s, and slowing down to 2 % annual growth after 2010 due to restrictions in the definition of eligibility by the National Social Security Institute (INPS) (Gori & Morciano, 2019, p. 544). The amount of the free-to-use national care allowance has remained relatively stable over time (including inflation adjustment) (2020: 520 Euros per month): The IA can be complemented by long-term care substitute benefits at the regional level, which are mostly income-based. In 2015, as shown in Table 1, 63 % of those in need of long-term care received the IA – trending upward since 2000; by contrast, the use of community care services was 28 % and residential care services as low as 9 % in 2015 – trending downward since 2000 (Gori & Morciano, 2019, p. 545). This corresponds to the fact that public funding for long-term care services was cut by 25.1 % between 2005 and 2016 (Jessoula et al., 2018, p. 7).[6]

Efforts to extend and create better in-kind services, such as the LTC fund, set up in 2007, were limited, as the size was too modest relative to investment needs (Maino & Neri, 2011). Consistent with the relatively low funding for in-kind services, the formal sector is relatively small, with 260,532 workers in 2016 (Jessoula et al., 2018). The share of migrant workers in this sector has been reported at around 10 %, which would roughly correspond to their average share in the overall labour market (see Da Roit & Weicht, 2013). Although migrants are becoming more relevant in auxiliary health professions, e.g. as nursing assistants (OSS – operatore socio-sanitario), there is little – if any – reliable data regarding the presence and profile of migrants in this field (Castagnone & Salis, 2015). By contrast, the total number of domestic and care workers employed in private households is estimated by the National Association of Family Employers *DOMINA* at circa 2 million (De Luca et al., 2020), with informal employment predominating. For example, INPS reports the number of registered – and thus regularly employed – workers in private households to be 848,987 in 2019 (INPS, 2020). The majority of workers employed in private households are women (89 %). The share of migrant women is 70 % and among live-ins as many as 91 % (De Luca et al., 2019). Most of the registered migrant care workers come from Eastern Europe, with Romania (33 %)

6 Hence, a large share of public expenditure for long-term care (46 % of Italy's LTC budget for the population older than 65 in 2019), is spent on the cash-for-care benefit IA (Gori & Gubert, 2020)

as an EU member state and Ukraine (18 %) as well as Moldova (12 %) a Non-EU member as most important countries of origin (INPS, 2019). Thus, the incorporation of migrant workers in elder care provision in Italy manifests mostly as the widespread diffusion of the migrant-in-the-family model (Bettio et al., 2006).

Unlike other countries, *the demand for and employment of migrant domestic workers* in Italy was not completely novel. While in the first half of the 20th century domestic service used to be a feature of upper-class households and a status symbol of the rich, in the course of post-war economic growth this service already became more and more available to middle-class families. Although most domestic workers at that time were internal migrants from poorer regions, employment of migrant women became more frequent from the 1970s onwards (Sarti, 2010). These women came from former colonies, or were recruited via Catholic priests for example Eritreans (Marchetti, 2014), Cape Verdeans (Andall, 1998), Filipinas (Parreñas, 2001), as well as Latin Americans (Skornia, 2014). By the mid-1990s foreigners made up half of all domestic workers (Sarti, 2008, p. 87). From then onwards, the rising need for elder care, the relatively low relevance of formal (outpatient and inpatient) service provision and the availability of the cash-for-care benefit as the most prominent pillar of LTC policy paved the way for employing migrant care workers in households across classes, though the odds of hiring a live-in are higher in households with higher education status (Fisher et al. 2021). While Filipina and Peruvian women are said to have been the first migrant care workers who over and above cleaning and childcare duties also carried out elder care, women from Eastern Europe predominate in the meantime (Bettio et al., 2006). The recruitment of these workers is facilitated by informal networks and local institutions, including parishes and trade unions.

On the *supply side*, as in other Western countries, these developments were made possible by the inflow of foreign workers from former communist countries, where the socio-economic transformation had caused mass unemployment and a worsening of living and working conditions acted as a push factor for migration. The societal transformations in *Romania* may serve as an illustration, since Romanians have become the largest national group amongst migrant care workers in Italy. The collapse of the communist dictatorship in the late 1980s was followed by political and economic crises. De-industrialization processes led to poverty, high unemployment and reverse internal migration from urban to rural areas. International migration became a viable option for many Romanians, who sought to provide for themselves and their families through employment abroad. Entry into Italy was first eased for Romanians when visa requirements for stays below three months were dropped in 2002. This fostered temporary, circulatory migration patterns, which had already begun to take shape in the late 1990s: the transnational practice of 'commuting', encouraged by geographic proximity, meant that work and family relations were kept intact in both countries (Verbal, 2010). Soon after the visa waiver, there was a significant increase in Italian residence permits issued for Romanians (Torre, 2008). With EU accession on the horizon and easier access to the Schengen area, migration intensified, and by the end of 2008, after one year of EU membership and the right to mobility within the EU, Romania became the number one sending country in Italy (with a total of 796,477 residents), surpassing Albania (441,396) and Morocco (403,592) (Verbal, 2010, pp. 143/225). Since 2002, the numbers of Romanian women going to Italy have been higher than those of men, reflecting the gendered workforce demand in care work. Moreover, the cultural and linguistic similarities between the two countries have eased adaptation and integration processes, which

is why Spain is the other main destination for Romanians alongside Italy (Sandu, 2017).

Finally, in 2012, Romanians gained legal access to the Italian labour market, which further fostered the already established transnational work migration from Romania to Italy. Repercussions of this migration on the situation in the country of origin may be seen not only in the important economic role of remittances but also the political engagement of migrant workers who returned to the country for anti-corruption demonstrations in 2018 (Ciobanu, 2018).

As this example shows, the supply of this migrant workforce was not only sustained by demand working as a pull factor and push factors such as mass unemployment, but also by enabling factors such as political regulations allowing easy access to the country of destination. Indeed, the Italian *migration regime* has been characterized by laissez-faire and ad-hoc measures, which is why its borders were relatively permeable and led to Italy being perceived as one of the Schengen Area countries with more open external borders (King & Zontini, 2000). Instead of controlling migration flows ex ante, Italy engaged in ex post regularization campaigns, which throughout the 2000s increasingly targeted domestic and care workers (Bettio et al., 2006). The regularizations took place in 2002, 2009 and 2012, each followed by a sizeable increase in regularly employed domestic and care workers, though the majority continues to be employed in the grey market (Da Roit & Le Bihan, 2019). Although these legalization efforts primarily addressed migrants already living and working in Italy, the existence of such measures certainly fostered perceptions of Italy as a destination with promising opportunities for legalizing one's stay.

Finally, also relevant for the successful demand and supply side interaction and thus the *sustainability of the migrant-in-the-family model* is an infrastructure of social partners, namely organizations of family employers and trade unions, which address the widespread service provision in private households. In 2020, for example, a national collective agreement existing since 1974 was renegotiated for the tenth time for domestic and care workers regularly employed in private households; among other aspects this agreement addresses the special burden on live-in care workers who care for multiple adults. Regional and local authorities and actors may shape the market of migrant care work by fostering training programmes to improve the quality of care or by providing families with financial incentives to transform informal care workers into regular workers. For example, in Tuscany, the experimental project Pronto Badante has sought to advise families with urgent care needs, grant a financial bonus and match families with a regular care worker. Apart from this exception however, regional efforts produce rather modest results in the absence of national policies and unstable resources (Paquinelli & Rusmini, 2021). Further research is needed to determine the extent to which migrant workers in private households switch to the formal sector of outpatient and inpatient care.

3.3 Sweden

Sweden is considered to have one of the most comprehensive elder care systems in Europe, with generous public spending, a large public sector and universal services (Meagher & Szebehely, 2013, p. 59). In 2018, according to OECD data on public spending on long-term care as a percentage of GDP, Sweden's expenditure was the second highest of 30 OECD countries that provide respective figures and, for example, twice as high as Germany's (Rothgang & Fischer, 2019, p. 651). In contrast to many other European countries, the Swedish welfare state started to implement explicit LTC policies and provide public care services as early as the 1950s (Trydegård, 2000, p. 23). Since the Social Service Act (Socialtjänstlag) of 1980

Table 2.
Regions of origin among migrant elder care workers in Sweden (in %)

	Care assistants	Assistant nurses	Registered nurses
Africa	30.5	23.4	10.3
Asia	40.8	34.1	27.1
Europe	23.1	34.8	56.3
other regions	6.6	7.7	6.3

Source: own calculations based on Statistics Sweden, 2020.

all citizens are entitled to tax-funded formal home and nursing home care provided by professional care workers. Under the 1992 Ädel reform, responsibility for residential care and care facilities was transferred from the regions (healthcare) to the 290 municipalities (social care), which are responsible for assessing care needs and organizing service provision (through municipal services or private providers). The majority of care services are provided in the form of home care; for example, in 2018, approximately 8.3 % of all persons over the age of 65 received home care services and approximately 4 %, i.e. half as many, received care in nursing homes (Socialstyrelsen, 2019). By contrast, informal home care by relatives plays only a secondary role, and a so-called informal market of domestic services is assumed to be small and limited to domestic work such as cooking, cleaning and other household tasks on an hourly basis (Kvist & Peterson, 2010; Hobson et al., 2018).

Against the backdrop of rising long-term care needs, increasing financial and economic pressures and rising funding needs in other care sectors as well (e.g., for people with disabilities), municipalities have made eligibility criteria for care services more restrictive; for example, the share of people over 80 receiving formal long-term care fell from 62 % to 37 % between 1980 and 2015 (Stranz & Szebehely, 2018). At the same time, capacities for care, particularly in the prioritized area of home care, have been expanded since the early 1990s as part of New Public Management strategies through the licensing of private providers for care services (Local Government Act 1991 and Act on Public Procurement (LOU) 1992 and 2007) and the introduction of choice for household and care services (Act on System of Choice in the Public Sector (LOV) 2009). This was accompanied by a growth in demand for labour and simultaneous worsening of working conditions and more insecure contracts – developments that led to labour shortages *and increased recruitment of migrant labour*. Contrary to van Hooren's claim that social democratic care regimes such as in the Nordic countries do not need migrant care work, Sweden has also seen a 'migrantization' of its LTC workforce.

Based on data provided by Statistics Sweden in 2020, the share of migrants working in the three main elder care occupations (registered nurses, assistant nurses and care assistants) increased from 16 % in 2005 to 19 % in 2010, 22 % in 2013 and 32 % in 2018 (own calculations based on Statistics Sweden 2020). In the same year, the share of migrant workers among all employed persons aged 16-64 years was only 19.5 % (Statistics Sweden, 2019). The different occupational groups, however, show different degrees of migrantization; in 2018 the share of foreign-born workers was nearly 40 % among care assistants, 29 % among assistant nurses, and only 16 % among registered nurses. We can also see that the backgrounds of migrant workers (regions of origin and grounds for settlement) differ with regard to their occupational status. Especially racialized workers from regions of Africa and Asia are segregated into low-skilled, low-status groups like care assistants, where-

as highly skilled positions of registered nurses are filled by migrant workers from other EU countries (Table 2).

The diverse backgrounds of migrant care workers are also reflected in their different migratory routes and grounds for settlement. In recent years there has been an increase in the numbers of refugees, asylum seekers and family reunifications. Among care assistants, 78 % of all migrant workers entered the country on the grounds of these entry categories, among assistant nurses the share is 64 % and among registered nurses, 47 %. In addition, migrants from other EU member states mainly entered on the grounds of EU mobility. By contrast, work permits for non-EU citizens play a marginal role for the care workforce and make up only 1 - 3 % of the entry categories in all occupational groups

It is also striking that the proportion of men among migrant care workers (20 %) is significantly higher than in the sector as a whole (12 %) (ibid., own calculations based on Statistics Sweden, 2020). Hence, the integration of migrants in long-term care provision in Sweden is mainly manifested through the migrant-in-formal-care model.

The characteristic features of service provision in long-term care in Sweden, i.e., the dominance of formal service provision, the high relevance of home care and the relatively minor importance of family care, reflect the social democratic welfare regime with public responsibility for care and a gender regime characterized by the "adult worker norm". What has not yet been explained, however, is the migrantization and increased stratification of workers in long-term care, especially against the backdrop of the egalitarian orientation of this welfare regime. In order to explain these processes, we have once again to analyse the interplay between the demand and supply side, embedded in the care and migration regimes.

As in other Western countries, demographic changes and an ageing population lead to increasing care needs that cannot sufficiently be met by family care-giving. Due to an already high labour force participation of the (male and female) working age population, the *rising workforce demand* for the expanding elder care sector from the 1990s onwards could not be met and shortages, especially of qualified care personnel, arose (Theobald, 2018, pp. 10-11). While childcare and healthcare services traditionally have been provided by public (municipal) institutions and relied on a professional workforce, the subsequent expansion of long-term care services was governed by the introduction of private providers for household and care services. At the same time contract and working conditions became more precarious making the sector less attractive. In the absence of nationally regulated staffing ratios and training levels, existing staff shortages can be mitigated by hiring lower-skilled workers. In 2015, registered nurses with a three-year university degree accounted for less than 10 % of all elder care workers, while the majority of elder care workers were assistant nurses (53 %) and care assistants (32 %). In these occupational groups, qualification levels are not regulated on a national scale; instead, municipalities play a central role in deciding what training and qualification levels are sufficient and how staffing is implemented by care providers. Thus, qualification levels vary between a three-year upper secondary education and a six-month adult vocational training for assistant nurses and a lack of any formal training for some care assistants (Moberg et al., 2018). As a consequence, elder care is often regarded as a low-skilled, low-status job, providing an 'easy' entry point into the labour market. Indeed, these institutional features facilitated the employment of migrants.

The *supply of this specific workforce* in turn rests on specific national conditions relating to the status of migrants and the *migration regime*. For a long time, Sweden has been described as a migration-friendly regime, especially with regard to asylum, refugees and family reunifications (Dahlstedt & Neergaard, 2019, p. 122). Between

1980 and 2018, 37 % of all residence permits were granted for family reunifications, representing the largest group of immigrant categories (Migrationsverket, 2019). Large waves of asylum seekers arrived in the early 1990s following the Yugoslavian war, and 2010s following regional conflicts and wars in Syria, Afghanistan, Iraq, Iran, Somalia and Eritrea (Skodo, 2018). In 2015, Sweden became a major recipient country of asylum seekers with the highest per capita number of asylum applications in the EU. While humanitarian reasons have been at the centre of the open asylum policies, policy makers stressed the economic value of incoming refugees and saw them as 'investments' and 'assets' for the economy (Hansen, 2018, p. 131). However, by the end of 2015, the Swedish government had shifted its migration-friendly position away from one of the most open immigration policies in the EU to the 'EU-determined minimum level of benefits and rights for protection beneficiaries' (Fratzke, 2017, p. 24). Since then, migration policies not only restricted inflows, but also increased pressures on immigrants to find employment quickly; directly, by making permanent residence permits conditional on economic self-sufficiency and (for some groups) family reunifications, and indirectly, by lowering the levels of benefits and rights (Fratzke, 2017, pp. 10-15). This development, and political pressure, have been exacerbated by right-wing and anti-immigration discourses and movements.

At the same time, compared to Swedish-born workers, it is more difficult for migrants to get access to the labour market, and this gives rise to a segregation into lower-skilled and lower-paid segments (Jönson & Giertz, 2013, p. 822). Moreover, some research indicates that migrants experience subordination and discrimination and are less likely to voice concerns, although it is assumed that they get the same contracts, working conditions and wages as their Swedish-born colleagues (Behtoui et al., 2020). The expanding care sector, with its low standardization in qualification levels, especially in the lower occupational positions, provides a low-threshold entry opportunity that is also taken up by male migrants, especially since the sector is characterized by better social security and higher social recognition compared to other low-skilled jobs in the service sector. As a result, the employment of migrants has become an important pillar of Sweden's dominant formal service provision in long-term care. Local politicians and administrations responsible for the organization and provision of elder care services perceive this development as a necessary solution to two major societal challenges: the integration of migrants and refugees into society on the one hand and the provision of elder care services for an ageing population on the other hand.

3.4 Poland

Poland has no explicit, coherent long-term care policy. Rather, as in other Central and Eastern European post-socialist states, regulations supporting those in need of care and their family carers belong to different policy areas (chiefly healthcare, disability and pension policies). There are care options in inpatient facilities for the sick or those in need of the most intensive care (Law on Healthcare Services Financed from Public Funds, 2004), while the social welfare system provides for municipally financed care facilities for the elderly and home care for those in need of care who are not cared for by relatives. Furthermore, there is financial support for family care-givers (Law on Family Benefits, 2003) and a lump-sum care allowance for persons over 75 years of age, which is granted in addition to the pension, regardless of need. The costs of this cash benefit in the pension system by far exceed care expenditures in the healthcare system and in social welfare (Golinowska & Sowa, 2013, p. 11). Attempts by individual political actors to reform this fragmented system, such as a proposal in

2007 to introduce a long-term care insurance system based on the German model, or a proposal to introduce a means-tested, tax-financed voucher system in 2015, failed, as did an initiative by the Ministry of Labour and Social Affairs in 2014 to relieve the financial burden on municipalities as operators of long-term care facilities for the elderly (Safuta, 2021).

Against this background, the lion's share of elder care is provided by (mostly female) family members. PolSenior, a large-scale survey investigating the care needs of people over 65 in Poland, showed that 93.5 % (N=1,245) of those respondents who declared themselves in need of help reported family members as providers of support (Błędowski, 2012, p. 457). Neighbours, friends and acquaintances came second, mentioned by 9.3 % of respondents. The percentage of respondents who reported receiving some kind of state-provided care ranged between 1.5 % of those aged 65-69 and 7.9 % of those aged 85-89 (Błędowski, 2012, p. 461). In the same vein, earlier reports state that out of all dependent adults, 83 % were exclusively cared for by household members, while only 2 % and 1.5 % received care from a public institution or a privately employed care worker, respectively (Kotowska & Wóycicka, 2008: 84). In 2002, even among people aged over 75 with a disability, only 2.4 % were residents of a residential care facility (Szweda-Lewandowska, 2009: 246). However, in recent years, informal or semi-formal employment of migrant women in higher income households in larger cities and especially in Warsaw seems to play a role, too. According to an AZER survey from 2005 (N= 5,547 Poles aged 18-64), 1 % of households with an adult person in need of care hired a private carer; in cities over 100,000 inhabitants this percentage was as high as 5 %. The average income per person in households employing a care worker or using paid institutional care was 138 % of the mean income, whereas the income per person in families relying only on their own care resources and unpaid institutional support was 91 % of the mean (Wóycicka & Rurarz, 2007). Among migrant workers in private households, women from Ukraine predominate; in particular, live-in care work has become an ethnic niche (Safuta, 2017, p. 174). The exact scale of the phenomenon is difficult to estimate, because most migrant care workers are employed without a legal contract. However, while most domestic and care workers in Warsaw work on the basis of informal, oral contracts, there are also some employers who agree to sign an official contract. On the basis of this contract, workers can obtain a work permit and a visa, and pay social insurance contributions. The latter allows access to the Polish free public healthcare system and possibly also pension benefits after several years. Since the wages employers declare to be paying by contract often do not match what they pay in reality, these employment arrangements are mostly 'semi-formal'. In most cases these workers also continue to be employed in other households on an informal basis (Safuta, 2017: 170). Although not all migrant care providers work on a live-in basis, the migrant-in-the-family model dominates in Poland, although it is still far less pronounced and widespread than in Italy or Germany. Unlike informal employment in private households, migrant workers so far seem to have hardly played a role in formal home and residential care provision, although evidence is difficult to obtain.

Data from the Ministry of Labour showing the number of work permits issued annually to foreigners, do not reveal the true number of migrants working in formal or informal LTC. According to the Polish Classification of Activities, work permits for LTC employment fall under the broader categories of 'households employing personnel' (which also includes childcare and domestic work) and 'healthcare and social assistance' (Krajewska et al., 2015: 19). The number of work permits and employers' 'declarations of intent to employ a foreign worker' delivered in those

two categories is negligible (Kałuża-Kopias, 2018: 38);).[7] Ministry of Labour data show that out of a total of 406,500 work permits issued to foreigners in 2020, 295,272 went to Ukrainian citizens, including 90,929 to women.[8] Along with qualitative observations, these official data allow us to estimate that Ukrainians are the most numerous nationality among migrant care workers working within private households (Safuta, 2017) and in residential care facilities.

The dominance of cash benefits in elder care and the strong role of female family members in care provision on the one hand, and the rather low level of formal home and residential care on the other, both match the logic of the familialist welfare regime in Poland, as typified so far especially with regard to childcare (Szelewa, 2017). In order to explain the more recent, less researched emergence of the migrant-in-the-family model and the role of Ukrainian workers in this arrangement we again turn to demand and supply factors. These factors interact specifically with migration policies, and Poland is simultaneously the country of origin of many migrant care workers active in Western Europe and a country of destination for migrant care workers originating mostly from Western Ukraine (Safuta et al., 2016).

On the *demand side*, in Poland, not only population ageing but also emigration threaten the capacity and/or willingness of Polish families to provide care for their relatives. While people aged 80+ constituted 2 % of the entire population of Poland in 2000, by 2017 they were already 4.3 % – a twofold increase resulting mainly from an increase in life expectancy (GUS, 2018, p. 25). At the same time, the percentage of Poles residing abroad, away from their parents and grandparents, is steadily increasing. In 2010, the Polish Statistical Office (GUS) estimated that 2 million Poles were living abroad, while in 2017, this number had already grown to 2.455 million (of whom 1.232 million were women) (GUS, 2018, p. 1).[9] As there is also a shortage of affordable formal residential and home care services, the demand for elder care remains partially unfulfilled, and so families who can afford it turn to hiring migrants for providing care at home.

Emigration aggravates the care gap, as it reduces the number of physically present relatives who can provide care in Poland. Migrating Poles care at a distance (over the phone, for example) or through intense effort during occasional visits (Krzyżowski & Mucha, 2013, p. 27). Some female migrants even travel to Poland for several months at a time to provide hands-on care to elderly or sick relatives (Pustułka & Ślusarczyk, 2016, p. 83). Most migrants financially support either their parents themselves or relatives who provide care in Poland (Krzyżowski & Mucha, 2013, p. 26).

On *the supply side*, migrant flows from Ukraine to Poland started in the 1990s (Brunarska et al., 2016: 115) after Ukraine regained its independence from the collapsed Soviet Union in 1991. The country experienced a prolonged economic crisis characterized by rising unemployment, especially among young people, rising prices, salary delays, and a drop in the purchasing pow-

7 Data from the national Social Insurance Institution (ZUS) cannot be used as a reliable source either, as only a small fraction of migrant workers is registered for social insurance purposes (Kałuża-Kopias, 2018, p. 39). Migrants from Armenia, Belarus, Georgia, Moldova and Russia, who can enter Polish territory on the basis of a simple declaration from a potential employer, use this as a way to enter the Schengen Area. This means that not all recipients of such a declaration stay in Poland. Additionally, Ukrainian citizens can enter the Schengen Area without a visa (for short stays) since 11 June 2017.

8 See https://psz.praca.gov.pl/web/urzad-pracy/-/8180075-zezwolenia-na-prace-cudzoziemcow (consulted on 26/04/2021).

9 These statistics only include temporary migration. See https://stat.gov.pl/obszary-tematyczne/ludnosc/migracje-zagraniczne-ludnosci/informacja-o-rozmiarach-i-kierunkach-czasowej-emigracji-z-polski-w-latach-2004-2019,2,13.html (consulted on 26/04/2021).

er of salaries and pensions (Marchetti & Venturini, 2014: 4). Along with the Czech Republic and Hungary, Poland became an attractive destination for Ukrainians seeking to escape deteriorating living conditions in their country of origin (Brunarska et al., 2016: 116). The intense emigration Ukraine has experienced since its independence further intensified since Euromaidan, the anti-government protests which erupted in Kyiv in November 2013. Official Polish statistics computing the number of residence permits issued to Ukrainian citizens show a steady increase in the number of migrants from Ukraine since the beginning of the war in eastern Ukraine in 2014. While the number of foreigners holding a residence card in Poland doubled between 2014 and 2018,[10] there was a fourfold growth in the number of Ukrainians holding such cards (Górny & Śleszyński, 2019: 332). Before Ukraine's transformation into a market economy in 1991, working-age women were expected to work outside of the home, while their mothers left the labour market early (until recently, the retirement age for women in Ukraine was set at 55) to care for their grandchildren and do the housework. The gender regime of post-1991 Ukraine is, however, based on a re-traditionalized nuclear male breadwinner model, which is not economically feasible and drives older women to migrate abroad (Solari, 2017: 29-30).

Poland's open *migration regime* towards labour migration from countries further east facilitated the emergence of a 'migration industry' in the form of Polish private-sector employment agencies that recruit Ukrainian workers directly in their home country and place them in EU countries, including for care work. Since 2006, Poland has a simplified procedure enabling citizens of Ukraine (as well as Armenia, Belarus, Georgia, Moldova and Russia) to work freely in Poland upon presentation of an employer's declaration. Since 2017, Ukrainian citizens no longer require visas to enter Poland and other EU member states, which allows easy access to the Polish labour market and formal and informal employment.

4. Comparative analysis

The four countries under scrutiny show *different patterns of migrantization*, which are summarized in Table 3. While we find a migrant-in-the-family model to be the main result of care migration in Italy and Poland, we see a predominant migrant-in-formal-care model in Sweden, and both models in parallel in Germany. Source countries of care migration are particularly Eastern European countries. While the MiF model in Germany, Italy, and Poland is mainly based on migrants who came in order to work as paid care-givers, the MiFC model in Germany and Sweden highly relies on migrants who entered the country for various reasons (e.g. as refugees, family reunification or labour migrants) and subsequently found work in the formal care sector. In comparison to Sweden, Italy and Germany, Poland stands out from these countries as it is both a destination country for care workers from Ukraine and a source country for care migration into Western Europe.

In Section 3 we have not only described these outcomes, but also analysed how these migrantization processes might be explained with respect to demand in the receiving countries, supply in the source countries and the respective migration regime (see Figure 1). In what follows we take a synoptic view of these four cases and draw some tentative generalizations from them.

10 Also partly due to the adoption in December 2013 of a new Law on Foreigners, which simplified the procedures for obtaining legal residence in Poland (Łodziński & Szonert, 2016, p. 57-58).

11 The level of care emigration was not an object of this study. In Germany, Italy and Sweden, however, it is way below the level of migrants in the care workforce.

Table 3.
Care migration in the four countries under observation

Migrantization	Germany	Italy	Sweden	Poland
Model of migrantization	Migrant-in-the family (MiF) Migrant-in-formal-care (MiFC)	Migrant-in-the-family (MiF)	Migrant-in-formal-care (MiFC)	Migrant-in-the-family (MiF)
Predominant source countries	MiF: Poland MiFC: particularly Poland and Bosnia	Romania, Ukraine, Moldova	Diverse, mostly Non-EU countries	Ukraine
Level of migrantization*	MiF: high MiFC: medium	MiF: very high	MiFC: high	MiF: low
Care emigration Level Destination countries Migration model	not relevant[11]	not relevant[12]	not relevant[12]	relevant Germany, Western Europe MiF and MiFC:

Note: The level of migrant care work is coded as high/medium/low if the share of migrant care workers is above/about/below the level of migrant workers in the whole economy.

Source: own presentation.

Considerable *demand for migrant care-givers* occurs if the joint capacities of informal (family) care-givers and affordable formal care services, be it home care or nursing home care, fall short of actual care needs. The reasons for such *shortages in domestic care-giving capacities* may vary. In Germany, the shift in the gender regime from a male breadwinner to a dual worker model has reduced family care-giving capacities. Payment and working conditions in formal long-term care, though gradually improving, have never been favourable enough to compensate this with a sufficient growth of formal care workers – with the capped LTC benefits being a major obstacle to further improvements. A decrease in family care-giving capacities due to the rise in female employment is also the underlying reason for domestic care-giving shortages in Italy, while in Sweden, retrenchment and marketization processes, precarious contract and working conditions as well as low qualification levels in the sector have reduced the status and attractiveness of the profession even more, leading to staff shortages. The Polish case adds another ingredient: the massive (non-care-related) emigration of Polish people has diminished family care capacities considerably, as particularly daughters and daughters-in-law who might have taken on care obligations are no longer available.

A second necessary condition, however, is the *availability of respective funds*. Thus, the migrant-in-the-family model in Germany and Italy is fostered by the existence of cash benefits that can be used to finance migrant live-ins. Without such benefits this model would be limited to wealthy households and could never develop into a mass phenomenon. The migrant-in-formal-care model also requires a demand for services and a corresponding demand for care workers respectively. As the German and the Swedish case seem to indicate, this condition can only be met if there is considerable public financing for formal care and – more or less qualified – care workers.

Apart from those necessary conditions there are also *supportive* cultural patterns that are favourable to certain developments. A cultural tradition of domestic servants as in the case of Italy might contribute to the growth in popularity of the migrant-in-the-family model, while the cultural acceptance of migrant care workers certainly increases the

probability of an important role of migrants in both formal and informal care.

Apart from a respective demand, migrantization also requires a matching supply. As the Swedish case highlights, one possible source is migrants who are already in the country. For migrants immigrating in order to work in care-giving, the central prerequisite on the *supply side* is the realization by potential care workers that there are job opportunities abroad and that the economic rewards are higher than in the domestic labour market. After the breakdown of communism followed by economic crises and rising unemployment in Central and Eastern Europe this condition was met for many women from these countries; especially working-age women were often highly affected by unemployment. Consequently, we have been seeing an ongoing migration flow from East to West. As the Polish case shows, within this care migration process a country can be both a source and destination country, thus causing care chains connecting more than two countries. For the migrant-in-formal-care model it is also necessary that potential migrants have the required qualifications at their disposal. Policies and programmes that support the fast integration of migrants into the labour market and vocational training facilitate the incorporation of migrants into higher-skilled positions. This is less important as long as migrants are predominantly employed as auxiliary personnel, but more relevant if they are employed as qualified (geriatric) nurses.

Even if there is a demand and a matching supply, migrantization depends on a favourable *migration regime* and – as far as high-skilled care migration is concerned – a *labour market regime* supporting the acknowledgement of foreign qualifications. While a residence permit is indispensable for employment in formal care, the grey market for live-ins may also work without it. For immigration from the accession countries into Germany and Italy in particular, EU enlargement opened up new opportunities and accelerated care migration, both for the migrant-in-the-family and the migrant-in-formal-care model. While in Germany, for example, live-in arrangements were long established in a legal grey area, for instance with tourist visas being used as residence permits, the full freedom of movement for the new EU countries from 2011 onwards facilitated care migration from Poland to Germany considerably. Even in Italy, where the practice of subsequent legalization has been dominant for years, freedom of movement eased care migration from EU countries. For live-ins from non-EU states the precarious residential status still exists. In Poland the emergent migrant-in-the-family model rests on open borders and easy access for workers from the countries further east. Sweden stands out because its originally broadly generous asylum and family reunification policies allowed immigration from non-EU countries and a correspondingly respectively diverse reservoir of migrants to tap into.

For migrants working in the formal care sector, the *labour market regime* is also of the utmost importance as the recognition of foreign professional qualifications is required – particularly for those who seek work as qualified (geriatric) nurses. Different recognition rules may therefore predict the countries of origin of migrants in formal care. However, if the formal care sector also takes on less qualified workers, which might be the case if home care services are expanding or are characterized by a workforce mix of more and less professional workers, access for migrant workers to the formal sector might be eased, too. This is the case in the Swedish welfare and migration regime, where fast labour market integration of migrants is facilitated and expected, hence non-EU migrants are channelled into the formal care sector, representing a labour market segment with a high demand for workers and working conditions comparatively unattractive to the native workforce.

Finally, a relatively novel supportive condition for the migrant-in-the-family model

Table 4.
Necessary and supportive conditions

	Migrant-in-the-family Migrantization	Migrant-in-formal-care Migrantization
Demand side	*Necessary conditions:* » Informal care supply is insufficient and » formal care is not sufficiently available or too expensive and » cash benefits or high income/ wealth allow for private financing of live-ins *Supportive conditions* » cultural tradition of domestic servants	*Necessary conditions:* » Labour shortages in formal care workforce and » informal care cannot compensate for this and » there is sufficient private and/or public financing for formal care services *Supportive conditions* » Migration care workers are culturally accepted
Supply side	*Necessary conditions:* Economic hardship (high unemployment rates, low wages) and Perception of work opportunities in the destination country or » Availability of migrants who are already in the country and are willing to work as informal care-givers	*Necessary conditions:* » Economic hardship (high unemployment rates, low wages) and Perception of work opportunities in the destination country and High number of (qualified (geriatric)) nurses or » Availability of migrants who are already in the country and identify care as a job opportunity
Migration and labour market regime	*Necessary conditions:* » Forms of semi-legal permanent or temporary residence permits *Supportive conditions* » Brokering agencies reduce transaction costs and facilitate the match of demand and supply	*Necessary conditions:* » Forms of legal permanent or temporary residence permits » Acknowledgement of foreign qualifications, if migrants are to be employed as qualified (geriatric) nurses *Supportive conditions* » Policies and programmes that support fast integration into labour market and vocational training of migrants as well as active recruitment by government and brokering agencies » Societal norm of active labour market participation for everyone

Source: own presentation.

should be mentioned. While originally transnational personal networks played a crucial role (and to some extent still do), in countries of origin (especially Poland) and countries of destination, *brokering agencies* have meanwhile established themselves. They reduce transaction costs, ease the matching of supply and demand and have become a promotor of this model in their own right (Rossow & Leiber, 2017; Leiber et al., 2020).

Table 4 summarizes the necessary and supportive conditions for the flourishing of the migrant-in-the-family and the migrant-in-formal care model. While some of these conditions are identical for both models, others differ, thus explaining why either of the models may preponderate. It is important to note that only the simultaneous fulfilment of all *necessary* conditions on the demand side and the supply side and for the migration and labour market regimes can be

considered as a *sufficient* condition for the occurrence of the respective model.

5. Conclusion

As our country case studies show, the timing of the introduction, socio-political regulation and levels of care provision vary, as does the role of migrant workers for the respective dominant forms of service provision in long-term care. The latter can be systematized according to our analytical concept, which takes into account the criteria of formal/informal employment relationships, (predominantly informal) domestic and (usually formal) residential and home care service provision, in combination with the role of migrant workers. Accordingly, the typical country-specific constellation for Sweden is a dominance of the migrant-in-formal-care model; for Italy and Poland a dominance of the migrant-in-the-family model, while Germany is characterised by the coexistence of the migrant-in-the-family and migrant-in-formal-care models. In all countries however, by now migrants have become a necessary pillar of long-term care-giving.

Explaining the emergence of these constellations shows that specific interactions of care policy with labour market and migration policy are relevant against the background of established gender regimes and welfare state type. In this framework, the economically, politically and socially influenced demand and supply of labour in countries of both origin and destination play an important role, and labour market intermediaries for workers and employers (especially private households) gain importance as new actors. In this respect, according to our findings, transnational labour migration proves to be an essential aspect of interdependency for the design of care policies and the profiles and dynamics of service provision in long-term care in Europe.

The process of migrantization also raises questions about the regulation of this process. This can clearly be observed in the German case: While regulators have for a long time turned a blind eye to informal migrant care-giving, recent initiatives rather suggest, that this strategy will be brought to an end in the near future and we might observe some formalization of hitherto informal form of care-giving. At the same time recruitment campaigns promoted by the health ministry might even reinforce immigration of care workers in formal care. In Sweden, the increasing incorporation of migrants into the care sector is regarded as a necessary solution to maintain the provision of elder care and is even promoted by local training programmes. In Italy, in the future regional and local governments and administrations alongside unions might become more important actors governing the dominant migrant-in-the-family-model while in Poland this model is still emerging.

While this kind of transnational interdependency takes centre stage in migration and labour market studies and has been widely addressed by care and gender studies, more research from a comparative welfare state research perspective is needed. Future research should focus on emerging dynamics such as trends towards formalizing care provision in the family as we have observed in Italy and Germany, or incentivizing informal care provision by social policy preferences for cash transfers rather than services in countries with a familialistic welfare regime as in Poland. As the demand for long-term care provision will continue to increase – not only in the global North – and the impact of the ongoing Corona crisis on perceptions and the structure of public health provision is still unknown, the analysis of long-term care should stay on the agenda of transnational and international social policy research.

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