Department of Political and Social Sciences

Caring migrants in European welfare regimes: The policies and practice of migrant labour filling the gaps in social care

Franca Janna van Hooren

Thesis submitted for assessment with a view to obtaining the degree of
Doctor of Political and Social Sciences of the European University Institute

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ABSTRACT

This study analyses the role of migrant workers in social care and the policy responses to this phenomenon in Italy, the United Kingdom and the Netherlands. In contrast to previous research on migrant care work, this study incorporates both private and agency-based employment in child and elderly care. It applies a comparative case study approach relying on micro level survey data, expert interviews, policy documents, newspaper articles and secondary sources. Theoretically the research engages with welfare regime theory and with theories on the politics of migration and the politics of the welfare state.

The demand for migrant workers in social care is strongest in elderly care. Cross country differences are related to variation in employment conditions. Migrant workers are overrepresented when social care jobs are badly paid, offer limited career opportunities and require extensive shift work. These employment conditions are significantly shaped by social care policies. It is argued that a Familialistic care regime, as demonstrated by the Italian case, fosters the emergence of a 'migrant in the family' model of employment. A Liberal care regime, as revealed by the UK case, induces a 'migrant in the market' model. By contrast, a Social Democratic care regime, as approximated by the case of Dutch elderly care, does not create any particular demand for migrant workers in the social care sector.

Differences in care regimes influenced Italian, British and Dutch migration and care policies divergently. In Italy the presence of private migrant care workers absolved the state from reforming its social care system and meanwhile relatively generous migration policies for migrant care workers were enacted. In the Netherlands strong stakeholders guaranteed continuous investments in employment conditions of the elderly care workforce and migration policies have not granted any privileges to care workers. UK immigration policy reform has tightened eligibility criteria for care workers; nonetheless, it is questionable whether public investments in elderly care are sufficient to attract enough native employees.

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In the 1980s, only 2 percent of Dutch children went to a day care centre. I was one of them. Although I only remember the biscuits with peanut butter we had for lunch, my parents' choice to let me attend a day care centre while they were working has certainly contributed to my interest in issues of work and care. In the neighbourhood in Amsterdam where I grew up, my parents' choice was not uncommon. It was only when I went to university that I realised that the norm in the Netherlands was still quite different. I then started to understand how my mother had sometimes struggled to defend her choice to work and not to be considered a bad mother.

My interest in cross national differences in the organisation of work and care was aroused when I went on Erasmus exchange to Lund University in Sweden. Tellingly, during the first seminar I attended, a Swedish (male) professor enthusiastically told us that he was expecting a baby and would therefore be absent for a couple of months soon. Even though my parents had always cared for me and my brother together, I was amazed. For a Dutch father (who still receives only two days of paternal leave) months of absence would be unthinkable.

I arrived at the European University Institute in Florence planning to write a dissertation about childcare policies in Europe. But in Italy I was struck by the great importance of migrant women caring for older family members. While I was learning Italian I started to read Italian newspapers and I was astonished by the apparently contradictory way in which immigrants were often openly reviled, while no one seemed to question the importance and desirability of migrant care workers. I then decided that the employment of migrant care workers and the political responses to this phenomenon were something worth studying.

By engaging in an entirely new research project, I did not choose the easy way. At times I have cursed myself for not sticking to my previous plans and for seeking the challenges and difficulties of such a novel topic. But I am happy I made this choice as migrant care work turned out to be an exciting topic that will undoubtedly continue to be an important issue in many (European) welfare states. Therefore, I would like to thank my supervisor, Martin Kohli, for sharing my excitement about this topic, for encouraging me to explore it, and for supporting me when the last difficult changes had to be made.

I most enjoyed gathering the empirical material. Interviews in Rome, London and The Hague, exploring survey data, browsing through policy documents, I found it all equally exciting. More difficult was the writing-up part, when I had to make choices and was confronted with all the things I had not done and could not do. I would like to thank my co-supervisor, Virginie Guiraudon, who encouraged me when things were difficult both professionally and

personally. I am also grateful to the two external Jury members, Chiara Saraceno and Anton Hemerijck, whose comments helped me to improve the final version of this dissertation.

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With my colleagues and friends at the EUI – Bianca, Michaël, Sacha, Niki, Bram, Stan, Chris, Sergi, Clara, Christel and others – I shared not only the ups and downs of life as a PhD student, but also many moments of great joy, varying from daily lunches to memorable holidays in Tuscan villas. I had great fun setting up an EUI Rowing Team, and am happy it still exists. Drinking a cappuccino after a workout underneath the Ponte Vecchio is one of my best Florentine memories, next to cycling through the beautiful Chianti. In the last difficult stage of writing, my Dutch friends – Rosa, Saskia, Rachèl, Cathelijne, Jeltje, Rini and others – have listened to me, encouraged me and cheered me up.

Mette, my friend, has always been there for me, no matter whether I was in Florence or she was in Marocco or New Zealand. Lieuwe and Ineke, my parents and Timo, my brother, have been my inspiration and their infinite belief in me has always been a warm support. And finally Diederik, my love, who came with me to Florence despite all the good reasons I could think of why he should not. While living with a PhD student cannot be easy, he has managed wonderfully. Together we enjoyed Florentine life. Meanwhile, his optimism, bad jokes, good advices and love helped me through every stage of this venture. Thank you!

Franca van Hooren

Bremen, 9 March 2011

1 INTRODUCTION

Throughout Europe, immigrants are becoming increasingly important as employees in caring occupations. In some countries migrant workers are employed by public and private care providers. British nursing homes, for example, often rely on employees coming from countries as diverse as Zimbabwe, Poland or the Philippines. In other countries one is more likely to find families engaging migrant workers privately to care for a family member. In Italy and Spain foreign private elderly carers have become so important that observers have spoken about 'the transition from a 'family' to a 'migrant in the family' model of care' (Bettio et al. 2006: 272).

The extent and type of social care employment migrant workers engage in differs across Europe, as do the policy responses to this phenomenon. Most Northern European countries do not encourage the employment of migrant care workers in their child or elderly care sectors. Some Southern European countries, by contrast, have issued large numbers of work permits to domestic and care workers. Recently, Austria regularised Eastern European elderly care assistants who were irregularly working in the country. By contrast, Great Britain actually tightened the eligibility criteria for obtaining a work permit for 'senior care workers'.

This research project attempts to answer two sets of research questions. First, why do families and/or care providers rely on migrant care workers? And why does the importance of migrant care workers differ by country and by type of care provided? Second, why do some states encourage or allow the employment of migrant care workers, while others discourage it or opt for alternative means to organise care services? And why is migrant care work sometimes encouraged even in a context of widespread anti-immigrant sentiments? These two sets of questions are strongly interrelated. The eventual aim of this study is to cast light on the circumstances under which immigration into caring occupations is most likely to occur and to understand how this is interrelated with and influenced by policy choices.

While migrant care work has become an important phenomenon, research assessing the role of migrant workers in social care from a comparative perspective remains scarce. Therefore, the first aim of this research project is to improve our understanding of the great variation in employment of migrant workers in social care. Included in the study are migrant workers employed in both child and elderly care services. A distinction is made between, on the one hand, employment by public or private organisations ('agency-based employment'), and, on the other hand, employment directly by families ('private employment'). To understand whether states encourage, allow or discourage migrant care work, developments in social care and immigration policies are studied. A distinction is made between policies that are directly

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targeted at migrant carers, and those that are only indirectly related to the employment of migrant workers in social care.

This study is based on a comparative case study analysis of Italy, the United Kingdom and the Netherlands. These cases differ substantially with regard to the role of migrant workers in social care, and the policy responses to this phenomenon. While in Italy migrant workers have become indispensable as private elderly carers, in the United Kingdom they have mostly started to work in formal agency-based care settings. Neither is very common in the Netherlands. Migrant workers play a limited role in agency-based childcare settings in each country, but au pairs and foreign nannies can be found everywhere, though most visibly in the United Kingdom. Policies have sustained the immigration of care workers in Italy, but mostly discouraged it in the United Kingdom and the Netherlands. The analysis of each of the three cases relies on micro level survey data, interviews with involved policy makers and interest group representatives, policy documents, parliamentary debates, newspaper articles and a range of secondary sources.

As for the theoretical contribution, this research project builds upon the few existing comparative studies of migrant work in social care (for example Redfoot and Houser 2005; Bettio et al. 2006; Williams and Gavanas 2008). Findings from these studies are supplemented with theoretical accounts taken from research on immigration (for example Piore 1979; Waldinger and Lichter 2003; Anderson and Ruhs 2008) and on welfare regimes and social care (for example Lewis 1998; Esping-Andersen 1999; Anttonen et al. 2003a; Ungerson and Yeandle 2007). Because there was, at the time of writing, no comparative research studying the policy responses to migrant care work, the analysis of policy developments relies entirely on theoretical accounts taken from the politics of migration (for example Freeman 1995; Guiraudon 2002; Schain 2006; Messina 2007) and the politics of the welfare state (for example Pierson 2001b; Bonoli 2006; Morel 2006; Morgan 2006).

1.1 Emerging gaps in social care and the importance of migrant workers

European societies are changing. First of all, European populations are ageing. While in 1970 on average only 1.8 percent of the Western European population (the later EU-15[1], see table 1.1) was more than 80 years old, in 2009 this had grown to 4.5 percent (see table 1.1) and it is projected to grow further in the future (OECD 2005: 101; OECD 2009b). Population ageing leads to a growing need for elderly care services. Although some scholars argue that older people live healthily for a longer period (for a review see Robine and Michel 2004), the

[1] The figures refer to the 15 countries that belonged to the EU after its enlargement in 1995.

'fastgrowing number of very old persons, in particular relative to the population at working age, is nonetheless expected to increase substantially care needs – and related spending – in the future' (OECD 2005: 20). Due to population ageing, the share of the population that falls into the age group expected to participate in the labour market is shrinking. While in 1970 there were still on average 18 people aged 65 and over for every 100 people of working age (aged 15 to 64) in the EU-15 (see table 1.1), in 2009 this dependency ratio had grown to 25 people aged 65 and over for every 100 of working age. Extreme cases are Germany and Italy, where the dependency ratio is 31 to 100. Low fertility rates and increasing longevity mean that the dependency ratio is projected to grow further in the future (OECD 2009a).

Table 1.1: Some demographic indicators

	Total fertility rate[1]		Share of population aged +80		Old age dependency ratio[2]	
	1970	**2009**	**1970**	**2009**	**1970**	**2009**
Austria	2.3	1.4	2.1	4.7	23	25
Denmark	2.0	1.8	2.0	4.1	19	24
Germany	...	1.4	1.9	5.0	21	31
France	...	2.0	...	5.1	...	25
Italy	2.4	1.4[4]	1.8	5.6	17	31
Netherlands	2.6	1.8	1.7	3.8	16	22
Spain	2.9[3]	1.4	1.5	4.7	15	24
Sweden	1.9	1.9	2.3	5.3	21	27
United Kingdom	...	2.0[4]	2.2	4.6	21	25
EU-15 average	2.4[5]	1.7	1.8	4.5	18[6]	25

Sources: Fertility rate, Eurostat (2011a); rest, Eurostat (2011b)
[1] The mean number of children that would be born alive to a woman during her lifetime if she were to pass through her childbearing years conforming to the fertility rates by age of a given year.
[2] Population aged 65 and over as a percentage of population aged 15 to 64.
[3] Data for 1971.
[4] Data for 2008.
[5] Average excludes Germany, France and the UK.
[6] Average excludes France.

Most child and elderly care is provided unpaid by family members (Bettio and Plantenga 2004). Parents – often mothers – care for their young children; children – mostly daughters – care for their elderly parents, and partners care for their dependent spouse or companion. However, the capacity and willingness of family members to provide such unpaid care has decreased due to processes of individualisation and changing gender roles (see e.g. Crompton 2006). Individualisation is related to higher levels of education and to the different demands of modern

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society[2]. These societal changes induce a greater emphasis on individual development, evident in changing attitudes, but also in structural developments: family ties become weaker as family types diversify, fewer people get married, more get divorced, and households become smaller (Kiernan 2004). This structural element of individualisation directly affects the capacity of family members to take care of each other. At the same time, changing attitudes can lead to reluctance to perform caring work or to reluctance to ask for family care.

Changes in gender roles are evident in the great increase of women in formal employment, which has been called a revolutionary change (Hochschild and Machung 1989). As can be seen in table 1.2, in 1970 the employment rate of women aged 15 to 64 averaged 39 percent in the EU-15, with a minimum of 27 percent in Italy and 30 percent in the Netherlands and Spain, and a maximum of 58 percent in Sweden. In the following decades, women's employment rates increased to an average of 52 percent in 1998 and 60 percent in 2008. The biggest increases took place in some of the countries that traditionally lagged behind. In the last decade, women's employment increased by 10 percent or more in Ireland, Italy, the Netherlands and Spain. In some countries, such as Germany, Ireland and the United Kingdom, a substantial part of women work part-time. Most outstanding in this respect is the Netherlands, where 60 percent of all working women have part-time jobs.

Table 1.2: Employment rates for specific groups of women and percentage of women working part-time

	Employment rates women:							% working part-time of all employed	
	aged 15-64			aged 55-64		Mothers[1], youngest child aged:			
	1970[2]	1998	2008	1998	2008	0-2	3-5	1998	2008
Denmark	...	70	74	42	50	71	78	26	23
Sweden	58	69	73	60	67	72	81	22	20
Netherlands	30	59	70	20	41	75	76	55	60
United Kingdom	...	64	67	39	49	54	58	41	38
Austria	...	59	66	18	31	58	67	23	31
Germany	46	56	64	29	46	56	64	32	38
France	46	52	60	28	36	59	71	26	22
Spain	30	37	56	19	31	55	59	17	21
Italy	27	37	47	15	24	51	52	22	31
EU-15 average	39	52	60	27	39	60	66	30	31

Sources: Employment rates by age group, OECD (2011d); Working mothers, OECD (2011b); Part-time employment, OECD (2011e).
[1] Data for 2008
[2] Data for the Netherlands and Ireland refer to 1971, data for Spain to 1972

[2] Although individualisation is a contested concept (see for example Beck and Beck-Gernsheim 2002) there are some common denominators on which most scholars agree.

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Table 1.2 also shows that the employment rates of mothers are often as high as or sometimes even higher than those of women in general, varying from 51 percent of all mothers whose youngest child is between 0 and 2 years old in Italy, to 81 percent of mothers whose youngest child is between 3 and 5 years old in Sweden. By contrast, employment rates of women in their late 50s and early 60s – the age cohort that is most likely to have a frail parent in need of care – are still relatively low, but they have increased by 12 percent on average, from 27 to 39 percent, in the EU-15 in just 10 years time. Since male employment has not decreased simultaneously, the increasing employment of women has large consequences for the organisation of care (Crompton 2006: 3). Individualisation and changing gender roles have led to a decrease in the availability of informal, family provided care services, while population ageing has led to an increase in the aggregate need for elderly care. These two trends together induce a greater need for paid care services, while the labour force available to provide such care services is shrinking.

In the mean time, in the past decades an acceleration of migration has taken place (Castles and Miller 2003: 8-9). Table 1.3 shows that the stock of both foreign born and foreign national residents as a percentage of the total population has increased everywhere in recent years. The strongest increases took place in countries in which immigration is a relatively new phenomenon, such as Spain and Italy. Castles and Miller also point at the feminization of migration (ibid.), meaning that an increasing share of migrants is female.

Table 1.3: Stocks of foreign born and foreign national immigrants as percentage of total population

Country of residence	Foreign born		Foreign national	
	1995	2008	1995	2008
Austria	...	15.3	8.4	10.4
Denmark	4.8	7.3	4.3	5.8
Germany	11.5	...	8.8	8.2
Italy	...	...	1.3	6.6
Netherlands	9.1	10.9	4.7	4.4
Spain	4.9[1]	14.1	3.4	12.3
Sweden	10.6	13.9	6.0	6.0
United Kingdom	...	10.8	3.4	6.8
European average[2]	9.0	12.1	5.0	7.6

Source: OECD (2010a: Part V, Country Notes)
[1] Data are for 2000 instead of 1995.
[2] Average of data presented in table

It is in this context of individualisation, changing gender roles and accelerated migration that we should see the employment of migrant care workers. Migrant workers in both agency-based and private employment seem to fulfil a need, providing cheap and flexible labour to a sector that

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requires it. The use of a migrant labour force to fill the gaps in social care might seem a convenient solution to address shortages in domestic labour supply. However, it also highlights a range of controversial issues. As will become clear in the subsequent chapters, migrant workers are sometimes employed irregularly under worse conditions than allowed by national minimum standards. The employment of cheap and flexible migrant workers might also negatively affect wages and employment conditions in the social care sector, because employers do not feel the need to improve these conditions if they find migrant workers willing to do the job. Moreover, immigration is a particularly sensitive issue in many western countries. Wide segments of the population in European countries feel threatened by immigration. As can be seen in table 1.4, this corresponds with increasing support for populist and extreme right-wing political groups that have made anti-immigrant positions their priority (Ignazi 1992). Although these parties are only rarely included in government, they have a substantial influence on immigration policy making (Schain 2006; Bale 2008).

Table 1.4: Election results of populist and radical right parties in recent national elections in selected European countries

Country	Year	Party	Vote share
Austria	2008	FPÖ & BZÖ	28.2
Netherlands	2010	PVV	15.5
Denmark	2007	DPP	13.9
France	2007	FN	10.4
Germany	2005	NPD	1.8
Italy	2008	LN	8.3
Sweden	2006	SD	2.9
United Kingdom	2005	BNP	0.7

Source: www.electionguide.org
French data refer to first round presidential elections, German data to constituency votes

As this short introduction has shown, the employment of migrant care workers is related to the social changes taking place in all European countries. Understanding under what circumstances care providers and families rely on migrant workers is one of the aims of this study. Policy makers can consider the employment of migrant workers in the social care sector both as a convenient solution and as a problem. Therefore, how governments address the employment of migrant care workers becomes an important empirical question and describing and explaining the policy responses to migrant care work is the second aim of this study.

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1.2 Limitations of existing research

Migrant care work has been studied from several perspectives. One is the 'global care chain' literature, which maintains that global inequality and poverty drives poor women to leave their own family behind, in order to work for wealthy households elsewhere (Ehrenreich and Hochschild 2002). These scholarly works (see also for example Anderson 2000; Hondagneu-Sotelo 2001; Parreñas 2001; Lutz 2008) concentrate on personal care relationships. They are mostly ethnographic and focus on the vulnerability and exploitation of the migrant women involved. Some claims are made regarding the causes of migrant care work. One is the masculinisation of women's employment patterns (Anderson 2000: 11), another the 'absence or withdrawal of the state' from care provision (Kofman and Sales 2001: 102). However, these claims are not systematically verified. The global care chain literature is more concerned with a normative evaluation of the phenomenon of migrant care work than with a comprehensive explanation for it.

Only a limited number of scholars have attempted to comparatively assess how the role of immigrants as care providers is shaped by contextual factors in different countries. For example, Williams et al. interviewed migrant nannies and their employers in Britain, Spain and Sweden and compared their experiences and preferences (see chapter 5 in Lister et al. 2007; and Williams and Gavanas 2008). In another important contribution, Bettio et al. reveal the importance of private elderly care workers in Southern Europe and introduce the 'migrant in the family' model of care (Bettio et al. 2006).

These studies focus on the role of migrant workers in private, informal care settings, with care workers being directly employed by families. The role of immigrants in agency-based child and elderly care settings has received limited attention. It is only recently that scholars and international organisations are beginning to grasp the importance of this phenomenon (but see Redfoot and Houser 2005; Cangiano et al. 2009; OECD 2009a). In general there is a lack of systematic and comparative analyses of the role of migrant workers in different types of care settings – formal, informal, at home or in institutions –, for different groups – children and the elderly –, and in different countries.

Scholars have studied public policies related to migrant care work even less than migrant care work itself. While it is acknowledged that policies affect the demand for care work (Bettio et al. 2006; Lister et al. 2007), it is not assessed how these policies have come about or how they are affected by the growing presence of migrant workers. For example, Bettio et al. suggest that 'the hiring of immigrants might hinder the growth of an alternative market or public suppliers' (Bettio et al. 2006: 274); but they do not present empirical material to support this

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claim. They also do not consider why immigration policies in Southern European countries sustain the immigration of care workers.

Most studies of care in relation to social policy implicitly assume that this is a uniquely national phenomenon (see for example Lewis 1998; Anttonen et al. 2003b). In general, scholars studying social policy usually assume implicitly that welfare states are closed systems. That welfare states can be affected by international developments is only taken into account in relation to European integration or to the globalisation of markets and concomitant fiscal pressure. An exception is the growing body of literature on cash for care benefits. Several authors point at the impact of cash for care benefits on the demand for migrant care workers (Da Roit et al. 2007; Ungerson and Yeandle 2007). These studies will be further discussed in the next chapter.

When the intersection of social policy and migration is studied, this is done usually in relation to immigrants as welfare dependents. Some scholars have assessed why states granted social rights to immigrants (Soysal 1994; Guiraudon 2000) and how this differs between welfare regimes (Sainsbury 2006). Others concentrate on the challenges that immigrants pose to welfare states. For example, in their edited volume on immigration and welfare, Bommes and Geddes study 'the ways that international migration in its various forms structurally challenges the organisation and conceptual borders of national welfare states' (Bommes and Geddes 2000b: 1; cf. Crepaz 2008). However, no attention goes to the role of immigrants as welfare providers or employees in welfare state institutions.

This research project builds upon the few existing comparative analyses of migrant care work. Findings from these studies are supplemented with theoretical accounts derived from other literature, as was summarised in the beginning of this introduction. The theoretical framework is developed in chapter 2.

1.3 Understanding social care and migration

Knijn and Kremer define care as 'the provision of daily social, psychological, emotional, and physical attention for people' (Knijn and Kremer 1997: 330). The word 'daily' in the definition implicitly excludes cure-oriented medical care. Daly and Lewis use the term 'social care' to distinguish it from medical care. They define social care as 'the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children'[3] (Daly and Lewis 2000: 285). Contrary to Knijn and Kremer, Daly and Lewis explicitly relate their

[3] Included in their definition is also 'the normative, economic, and social frameworks within which these [activities] are assigned and carried out'. I believe this definition, which includes normative, economic, and social frameworks within it, risks stretching the concept of (social) care and thereby loses its utility.

definition to *dependent* adults and children. Waerness suggested differentiating 'necessary' and 'unnecessary' care by drawing a distinction between caring and servicing (Waerness 1987). She calls caring for an able-bodied grown up person 'servicing', yet terms providing such services for an ill or disabled person or for young children as 'caring'.

Although the distinction between caring and servicing can be difficult to realise in empirical research, the analytical distinction is relevant, especially in a discussion of social policies. In welfare states usually only the former (care for dependents) is considered to be an issue for policy intervention (Leira and Saraceno 2002: 62). In this study, social care will therefore be understood as *the provision of daily social, psychological, emotional, and physical attention for dependent adults and children.* Following the OECD definition, a dependent adult is understood as a person 'whose overall level of functioning is substantially reduced, such that they are likely to require help from a third party, or substantial help from aids and adaptations, in order to fulfil the normal activities of daily life' (OECD 2005: 17). A young child is by definition dependent on daily attention.

Included in this piece of research is care for young children up to primary school age and care for dependent elderly people aged over 65. In practice 'services for both groups [children and elderly] are rarely based on the same principles' (Daly and Lewis 1998: 2). Therefore, including both groups in this research project allows me to compare different sectors of care both within countries and between countries. For reasons of parsimony, the group of adults and children who are dependent on care due to a physical or mental disability is left out. This group would represent a variety of persons with many different needs: a variety that goes beyond the scope of this research.

An often used concept in relation to care for the elderly is 'long-term care'. The OECD defines long-term care as a range of services for persons who are dependent on help with basic activities of daily living, such as bathing, dressing, eating, or moving around (OECD 2005: 20). These services exclude cure-oriented health care and 'lower-level social care such as housekeeping, transport and social activities' (ibid.). Such a distinction between long-term care and lower-level social care is not made in this study. Hereafter, long-term care refers to the subset of social care that is targeted at dependent adults.

Social care can be provided in a variety of ways (Sipilä et al. 2003: 13). Most care is provided unpaid by family members. For example, a European study found that between 50 and 70 percent of people aged 50 with moderate of severe disabilities received some form of unpaid informal (often family) care in 2004 (see Appendix table A-2). In addition, care services can be purchased on the market, they can be provided by the state or by voluntary organisations. The extent to which non-familial care is available and used differs significantly by country. Table

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1.5 gives some indications of the non-familial care services used in different European countries. However, the table should be interpreted with care because data sources differ by country and can lead to imprecise and sometimes incomparable results. For example, elderly care data for the United Kingdom, Germany and Spain refer to both publicly and privately funded services, while data for other countries include only services that were either publicly organised or at least partly publicly funded. In the table, elderly care recipients in institutions refer to the number of people aged over 65 who reside in a residential care or nursing home. Elderly care at home includes care provided to people with functional restrictions who mainly reside at their own home. Sometimes these data also include cash for care benefits. Agency-based childcare consists of care in day care centres and preschools. It excludes childminders, nannies, and other forms of care that involve a direct relationship between the parents and the carer, but it includes forms of care that are provided only for a few hours a week. Therefore, separate columns refer to the percentage of children that attended care centres for more than 30 hours per week. While the data presented in table 1.5 may not represent the exact service coverage rate for every country individually, they do give a good indication of how the different countries compare. Similar cross-national differences were found in other data sources (see for example Anttonen and Sipilä 1996; Bettio and Plantenga 2004; Saraceno 2010).

The use of both child and elderly care services is clearly above average in Denmark and Sweden. In both countries child and elderly care services are largely publicly funded and (especially in Denmark) many children attend day care centres for more than 30 hours per week. In the Netherlands, the use of elderly care services is among the highest in Europe. These services are mostly funded through a universal social insurance that was introduced already in 1968. On the contrary, the use of childcare services was traditionally much more limited. In recent years, the use of childcare has increased strongly, but, as table 1.5 shows, only 6 percent of all Dutch children aged 0 to 2 yours old attends a childcare facility for more than 30 hours a week. Others attend playgroups that provide care only for a few hours a day. A similar story can be told about the United Kingdom. This country is also a historical laggard with regards to childcare services which recently caught up, but here too, most childcare services are used on a part-time base. Similar to the Netherlands, the UK has a long history of institutional elderly care, but recently the number of people receiving both institutional and home care services has decreased.

France (as well as Belgium) developed extensive services for young children at an early stage. In Germany and Austria services for both the young and the old were less extensive than in other North-Western European countries. Both countries established a long-term care insurance scheme in the 1990s. In Germany this insurance gives clients a choice between in-

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kind services and cash benefits, and in Austria all client get cash benefits. The very high percentage of home care recipients in Austria shown in table 1.5 refers to the people that received cash benefits through the long-term care insurance. Finally, publicly provided and financed elderly care services are least developed in Southern Europe, although it should be remarked that Italian dependent elderly receive a cash benefit that is not counted in the table. Childcare for the 3 till 5 year olds in Italy is provided through a comprehensive public pre-school system, but agency-based childcare for the very young is more limited.

1.5: Use of child and elderly care services[1] as percentage of all elderly/children in the same age group

	Elderly care recipients as percentage of population aged 65+ (2006)[1]		Agency-based childcare by child's age and average hours per week (2008)[4]			
			0-2 years old		3 years - compulsory education	
	in institutions[2]	at home[3]	total	>30 hours	Total	>30 hours
Denmark	5.4	12.9	73	65	97	83
Sweden	6.8	9.8	49	31	94	64
France	6.3	3.5	40	23	96	44
Netherlands	6.9	13.1	47	6	90	12
UK	4.2	6.9	35	4	87	20
Germany	3.7	6.6	19	9	90	36
Austria	2.6	13.8	7	2	71	20
Italy[5]	2.1	1.8	27	16	91	72
Spain	2.1	6.0	38	16	95	45
Average EU-15[2]	4.6	8.3	33	15	90	45

Source: Elderly care data, OECD (2009c); Italian elderly care data, Gori et al. (2003); Childcare data, Eurostat (2011c)

[1] Data for the UK, Germany and Spain include publicly and privately funded services. Data for other countries include only (partly) publicly funded services. For further details see: http://www.ecosante.fr. Data for Austria and for home care in France refer to people aged 60 and over. Data sometimes refer to the earliest year prior to 2006 for which data were available (see OECD 2009c for details).

[2] Institutional care refers to nursing and residential care facilities which provide accommodation and long-term care.

[3] Care at home is provided to people with functional restrictions who mainly reside at their own home. Data include care by paid long-term care providers and cash benefits granted with the primary goal of supporting individuals with long-term care needs based on an assessment of needs (excluded are attendance allowances).

[4] Data include only childcare at day care centres, pre-schools and other agency-based care. Child minders having direct arrangements with parents and childcare by grandparents, other relatives, friends and neighbours are excluded.

[5] Elderly care data for Italy are from a different source and include only publicly funded services.

[6] For elderly care the averages are based only on the data presented in the table.

Let us now turn to the definition of a migrant worker. In both migration research and migration statistics two different definitions for migrant workers are commonly used. According to a United Nations definition, a "migrant worker" is a person who is engaged in 'a remunerated

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activity in a state of which he or she is not a national'[4]. In this definition a migrant is understood to be a foreign national, which would imply that second and third generation immigrants are included, unless they have naturalised. The alternative is to define a migrant worker as someone who is born in another country than where he or she is now working. The advantage of this 'foreign born' definition is that it includes only people who have personally migrated. The disadvantage is that it also includes foreign born 'locals' (for example an Italian born abroad but living in Italy). The advantage of the foreign national definition, on the other hand, is that it includes only people who are by law different from nationals.

The rights of migrant workers can vary greatly depending on their country of origin and their immigration status. Citizens of countries that belong to the European Union have the right to move freely within the EU. In addition, with the exception of Romanian and Bulgarian citizens, they have the right to engage in employment in another member state. By contrast, third-country (non-EU) nationals are often dependent on (temporary) work permits; upon losing their job they may have to leave the country. Others third-country nationals entered through family reunification or as asylum seekers. Some immigrants may be able to obtain a permanent residence permit, or even choose to naturalise, accepting the nationality of the receiving country. The legal status of a migrant is important for this research. As will be discussed in more detail in the next chapter, it determines the options a migrant worker has. It makes an enormous difference whether someone can travel freely, can change jobs, is entitled to welfare benefits, or none of these. This study takes a flexible approach towards the definition of a migrant worker. Whether foreign-born citizens or foreign nationals are included depends upon data-availability. Where possible, different groups of migrants with different origins and different legal statuses are compared.

1.4 What follows

Hereafter, chapter 2 begins by setting out two typologies for analysing the type of social care employment in which migrant workers are engaged, and the policy developments related to this phenomenon. The chapter then proceeds by exploring theoretical accounts that can contribute to an explanation of both the importance of migrant care work and the policy reactions to the phenomenon. A series of expectations is derived from the relevant literature on immigration, labour markets, welfare regimes, the politics of immigration, and the politics of the welfare

[4] As it is defined in the UN *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (Part I, Article 2.1).

state. These expectations are used to guide and structure the subsequent empirical chapters. The last part of chapter 2 describes the methodological approach applied.

Chapter 3 concentrates on the Italian case study. It shows that migrant workers have become very important as private care workers, directly employed by families. Using a household survey it is assessed which kinds of families employ migrant care workers and under which circumstances these migrants work. The last part of the chapter shows that migrant care work has been widely endorsed by policy makers, because it provides a convenient solution for the need for care services. The chapter explores how these positive attitudes towards migrant carers were possible in a country in which anti-immigrant parties formed a part of several of the most recent governing coalition.

Chapter 4 discusses the case study of the United Kingdom. Agencies in the UK providing elderly care services increasingly rely on a migrant workforce, while migrant workers are underrepresented in formal childcare settings. Nonetheless, migrant workers are found to be important as childminders and nannies, but not as personal elderly carers. The UK Labour Force Survey is used to cast light on the circumstances under which migrant workers are employed. In the last part of the chapter it is shown that the British government has effectively stopped issuing work permits to migrant care workers from outside the EU. In the interim, there is no comprehensive alternative solution for staff shortages in the care sector.

Chapter 5 consists of the Dutch case study. Compared to Italy and the UK, migrant workers have a much less important role in social care in the Netherlands. They are underrepresented in agency-based care services both for children and for the elderly and they are only of limited importance as informal au pairs and nannies. It will be shown that high public investments in social care have ensured that this sector remained an attractive employment opportunity for native workers. Policy choices have consistently opted in favour of public investment and against immigration or the informalisation of care. However, the most recent reform of home care services might send the country in another direction.

Chapter 6 brings together the results of the three case studies regarding explanations for the employment of migrants in social care. It addresses the first research question concerning why families or care providing agencies employ migrant care workers. Chapter 7 comparatively assesses trends and variations in policy developments in the area of social care and migration, focussing on elderly care. The chapter addresses the second research question: why do some states encourage or allow the employment of migrant care workers while others discourage it? In the conclusion the findings from chapter 6 and 7 are combined to draw a more comprehensive picture of the different paths followed by different countries.

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2 MIGRATION, CARE AND THE WELFARE STATE: AN ANALYTICAL FRAMEWORK

This chapter presents a framework for understanding and explaining the role of migrant workers in social care employment and the policy developments related to this phenomenon. The first section concentrates on how to demarcate what should be studied. Some of the important elements of how to define a migrant care worker (what is care, what is a migrant worker) were already discussed in the introduction. What will be added in the beginning of this chapter is a typology of different forms of migrant care work. Furthermore, this section also develops a framework for understanding whether states encourage or discourage migrant care work. Few policies explicitly regulate or address migrant care work. Nevertheless, there is a range of policies that have an indirect importance for migrant care work and could hence be seen as indirectly encouraging or discouraging migrant care work. Both these groups of policies are studied, but a distinction is made between direct policy responses to and indirectly related policy developments.

The second section provides theoretical grounding for the first research question: why do migrants work in social care and why do migrants work more in some countries and in some types of care than in others? The section starts with a short review of the relevant literature. After that, other research on immigration and social care is used to flesh out a series of expectations regarding why migrants are employed in certain sectors, how employment conditions in social care derive, and how immigration policies affect the employment of migrant care workers. These expectations will not be empirically tested. They are used to structure and focus the empirical part of this study. The expectations are also not meant to be exclusive as causal factors, since other factors may appear to be important in the empirical work.

Theoretical grounding for the second research question – why some states encourage or allow the employment of migrant care workers while others discourage it or opt for alternative sources of employment – is explored in the third section of this chapter. There are hardly any studies that directly address the making of policies for migrant care workers. Therefore, this section relies on studies related to the politics of the welfare state and the politics of immigration policy. As for the first research question, a series of expectations is derived that will be used to structure the empirical work. All expectations are summarised in Appendix B. The fourth and final section presents the research method used in this thesis and its potential strengths and weaknesses.

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2.1 A framework for analysis: types of care work and types of policy developments

Types of care work

The introduction discussed in broad terms the definition of a migrant care worker. A migrant worker is flexibly defined as a person engaged in remunerated activities in a state of which she or he is not a national or in which he or she was not born. A care worker is understood to be employed to provide daily social, psychological, emotional, or physical attention for dependent adults or children (following Knijn en Kremer's definition discussed earlier). A care worker can be engaged in many different types of employment relationships, ranging from a private care assistant employed irregularly by a family to care for an elderly dependent, to a nursery nurse regularly employed in a day care centre. Migrant workers are not equally represented in each of these types of jobs. Therefore, it is useful to make a number of distinctions within the category of care work.

In the literature a distinction is often made between formal and informal care. What exactly these categories mean differs. Often formal care is defined as paid care, while informal care is seen as all forms of unpaid care. However, if we understand formal as 'officially sanctioned or recognised'[5], then not all paid care work is equally formal (Lyon and Glucksmann 2008: 103). For example, when a care worker works without employment contract, without social security coverage, or even without residence permit, this employment relationship cannot be called formal. A more promising distinction is given by Bettio and Plantenga, who define informal care as: 'all unregulated, mostly unpaid, activities on behalf of children, elderly relatives, or others' (2004: 86). Formal care, on the other hand is defined as 'provisions regulated by law or other contractual arrangement' (ibid.: 86). However, informal care is still seen as 'mostly unpaid'. Pfau-Effinger proposes to distinguish formal, semi-formal and informal care work. Formal care work is employment regulated by the conditions of a legal framework (Pfau-Effinger 2007: 11). Semi-formal care is paid work by family members; informal care is paid work by undeclared employees. Hence, Pfau-Effinger does not consider informal care to be unpaid work, but instead informal care is undeclared or irregular work. This distinction between formal and informal will be followed in this study.

In addition, a distinction is made between different employment settings. A care worker can be employed by a public authority, by a non-profit organisation, by a private for-profit organisation, or by an individual or family. Employment conditions in each of these settings can be different. In particular there can be a large difference in regulations applying to a care worker

[5] www.oxforddictionaries.com, definition of 'formal', second entry.

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employed by an agency (public or private) and by a household. For example, in the Netherlands a household privately employing someone within the home is exempted from paying taxes and social security contributions. As a consequence, the employee is also not covered by many social insurance schemes. Moreover, in many countries the labour inspection agencies cannot enter a private household to monitor whether people are working in compliance with legally required employment conditions.

Since, as will be further discussed later in this chapter, employment conditions are an important factor in understanding the employment of migrant care workers, it is useful to distinguish different types of employment based on whether the official employer is an agency or a household. Hereafter, agency-based employment is employment by an organisation in the public or private sector and private employment is the direct employment of a care worker by a household. Formal employment refers to declared employment in line with all employment and social security legislation. Table 2.1 summarises the four types of employment in social care that emerge from the distinctions between agency-based and private and between formal and informal employment.

Table 2.1: Types of employment in social care

		Employer	
		Agency	**Household**
Employment relationship	**Formal**	*1. Formal agency-based employment*	*3. Formal private employment*
	Informal	*2. Informal agency-based employment*	*4. Informal private employment*

The first type of care work that can be derived is *formal agency-based employment.* It includes all declared regular employment relationships between an organisation and a care worker. It includes employment by local authorities, as well as by for-profit and non-profit organisations. It comprises both home care – provided at the care receiver's home – and institutional care, such as care homes and nurseries. The second type is *informal agency-based employment*, which includes the same employment by an organisation as the first category, but this time when it is undeclared or irregular. The third type is *formal private employment*, which includes all

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employment relationships where the care receiver (or his or her family) is the direct employer of a care worker. In this category the employment relationship is declared and in line with national labour and social protection legislation. An example of this type of employment would be a childminder or care assistant who has a regular employment contract and pays taxes and social security contributions. Finally, the category of *informal private employment* includes all care work that takes place within the family home and is not declared or in line with national labour and social protection legislation.

It should be noted that in practice it is often difficult to draw a clear line between formal and informal employment. For example, an employee can be formally employed for 24 hours per week, while she or he in practice works 60 hours a week. Similarly, as the example of private employment in the Netherlands illustrates, an employee can be employed in line with national labour and social protection legislation and yet not be covered by the same legislation. When an employment relationship falls within this grey area between formal and informal employment, this will be indicated explicitly.

The case study chapters following hereafter will assess to what extent migrant workers are over or underrepresented in each of these four types of care work in child and elderly care. Migrant workers are considered to be overrepresented when the number of migrant workers as a percentage of all workers in the specific type of work is larger than the percentage of migrant workers in the entire labour force. Whether migrant workers are overrepresented in a type of migrant care work hence depends on the percentage of migrant workers employed in the country.

Finally, as was remarked already in the introduction, migrant workers from different countries of origin have different rights and opportunities. While nationals of the EU-15 (the fifteen countries of which the European Union existed prior to the 2004 enlargement) are free to work in any other EU country, nationals of the countries that entered the EU in 2004 and 2007 often face more restrictions. Migrants originating from countries outside of the EU are usually even more restricted in their rights and opportunities to work in an EU country. Where sufficient data are available, the situation of these different groups of migrant workers will be compared.

Policy developments related to migrant care work

In their analysis of the employment of migrant workers in long-term care, Redfoot and Houser find that:

> *Policy decisions also play a major role in the volume and patterns of international migration to provide long-term care. Sometimes the effects of*

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> *policy decisions are direct and intentional, but just as often, the effects are indirect and unintentional (2005: 13).*

This quote not only justifies studying policy decisions to see how they encourage or discourage migrant care work, it also suggests that we can distinguish different types of policy developments that are worth studying. Policy decisions are not always intentionally targeted at migrant care work. Yet policy decisions that are not directly targeted at migrant care work may nevertheless have an indirect and unintentional impact on the phenomenon. Although they do not explicitly target migrant care work, such policy developments nevertheless determine whether states de-facto encourage, allow or discourage the employment of migrant care workers. Therefore, in this study both the direct policy responses to migrant care work and some indirectly related policy developments are included (see Table 2.2).

Direct policy responses are policies that directly and intentionally concern the employment of migrant care workers. Examples include immigration policies that are specifically targeted at care workers – such as immigration quotas for care workers, or the regularisation of care workers that were employed irregularly –, or cash benefits that aim to promote the regular employment of migrant care workers. Important for identifying policies belonging to this group is the explicit intention with which the policy is enacted.

The group of policy developments indirectly related to migrant care work is more difficult to demarcate. There is a wide range of policies that potentially affect the phenomenon of migrant care work, ranging from naturalisation regulations to employment legislation and the institutional design of public care provision (Williams and Gavanas 2008: 15). This study focuses on developments in the two policy fields that are most directly related to the employment of migrant care workers, namely social care policy and labour migration policy. These two policy fields regulate respectively how social care is organised and whether foreign nationals can be employed in the social care sector. Policy developments in social care policies that will be studied are, for example, the policy responses to a demand for care services, attention for the employment conditions in the social care sector, or the provision of cash for care benefits. Examples of relevant developments in migration policies are (changes in) the entrance criteria for low-skilled migrant workers, general regularisations for irregularly employed immigrants, and the labour market restrictions applying to nationals of new EU member states.

For both direct policy responses and indirectly related policy developments it is attempted to distinguish between those (potentially) encouraging or allowing migrant care work and those discouraging it. Table 2.2 gives some examples of encouraging and discouraging direct policy responses and indirectly related policy developments. In each of the case study chapters developments in social care and labour migration policies are investigated separately.

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Table 2.2: Examples of policy developments related to migrant care work

	Direct policy responses	Indirectly related policy developments
Encouraging	- Regularisation of irregular care workers - Immigration quotas for care workers - Recruitment of foreign care workers	- Unregulated cash for care benefits - No response to increasing demand for care services
Discouraging	- Restriction of entrance criteria for care workers	- Public investments in social care services - Restrictive immigration regulations for low-skilled workers

2.2 Why migrants work in social care

In addition to a description of the importance of migrant care work, the aim of this thesis is to provide an explanation for why migrant workers are more often employed in social care in some countries than in others and more in some types of employment (see table 2.1) than in others. This section starts below with a short review of some explanations for the employment of migrant care workers found in previous studies. Research devoted to a systematic, comparative analysis of migrant workers as care providers is limited (Kofman 2008: 81), but three interesting exceptions will be discussed here. The elements raised by these authors will then be supplemented with findings from other strands of literature, such as the sociology of labour migration, care work and welfare regimes. From the discussed literature, some explicit expectations are derived which will be used to structure the empirical work in subsequent chapters.

Bettio, Simonazzi and Villa's article (2006) on the employment of migrant workers as private elderly carers in Southern Europe introduced the 'migrant in the family' model of care that has subsequently been referred to in many other studies. The authors highlight several factors that pull migrants into caring occupations in Southern Europe. The first is the demand for care work. While public provisions were inadequate, cash for care benefits stimulated the hiring of private care workers. Families then turned to migrant workers because of their low costs (Bettio et al. 2006: 278). Second, they emphasise the importance of a large underground economy which can easily accommodate irregular migrant workers seeking gainful employment. Third, the recurrent regularisations of irregular workers would make Southern European countries particularly attractive countries of destination for immigrants (ibid.: 275).

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The article by Bettio et al. brings up a number of very relevant elements, but in lacks systematic empirical support for their claims. On the one hand, the article relies mostly on general empirical indicators (the number of migrants present, the number of older people) and presents no specific data on the employment of migrant workers as care assistants. As a consequence, it is difficult to disentangle the causal mechanisms at work. For example, are care workers attracted by regularisations or are the regularisations introduced because of so many care workers being present? On the other hand, the article only compares similar (Southern European) cases with similar outcomes. Therefore, it cannot identify which factors really contribute to the demand for private care work, and which factors are actually of less importance.

The second work to be discussed is Williams and Gavanas' (2008) study that compares the employment of migrant workers in private childcare in Sweden, the United Kingdom and Spain. Williams and Gavanas criticise the global care chain literature for its focus on the minimal state support and lack of public childcare (2008: 14). The situation in Europe, they argue, is more nuanced. What needs to be studied is a 'dovetailing' of childcare regimes and migration regimes (Williams and Gavanas 2008: 15). Among the elements that need to be considered are: the extent and nature of public and market provision of childcare services, the cash benefits for childcare, the 'care culture'– understood as the 'dominant national and local cultural discourses on what constitutes appropriate childcare' (ibid.: 15), and immigration policies, settlement and naturalisation rights, employment rights, anti-discrimination policies and histories of migration. For example, they found that a preference for a 'mother substitution' for care and the absence of formal services encourage the reliance on migrant workers directly employed by families. Moreover, restrictive immigration policies drive migrant women into the 'unregulated world of domestic and care work in the home' (Lister et al. 2007: 161). The study of Williams and Gavanas combines very interesting empirical material with an encompassing theoretical framework. However, the theoretical framework, loosely including a wide range of different elements, is so broad that it is difficult to use as a starting point for new empirical research. Therefore, later in this section it is attempted to specify some of Williams and Gavanas' general theoretical assumptions.

The two articles discussed above have only focused on private care work. In a third work on the formal agency-based employment of migrant care workers, Redfoot and Houser note that various research on the migration of health care workers exists, yet 'little research has looked specifically at the international migration of long-term care workers' (2005: 3). According to Redfoot and Houser, the demand for different types of care workers with various skills differs by country.

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Redfoot and Houser criticise the neoclassical model of immigration for not explaining the demand for care workers and point instead at dual labour market theory (2005: 1). They argue that 'the relatively lower prestige and working conditions associated with long-term care are undoubtedly factors in the disproportionate numbers of migrating health care workers finding work in long-term care settings' (Redfoot and Houser 2005: 8). They point out that 'high turnover rates and vacancies exist for direct caregivers in many countries even under conditions of relatively high unemployment rates, which cannot be explained by neoclassic theories or by demographic arguments emphasizing structural shortages due to the aging of the population' (ibid.: 9-10). Redfoot and Houser also emphasize the importance of policy decisions, such as public financing of long-term care, the choice between cash benefits and agency-based services, and policies regarding immigration and naturalization. In relation to the latter they note that 'debates are very contentious in many countries' (ibid.: 14)

The three articles just discussed already bring to the fore many of the factors potentially affecting the employment of migrants in caring occupations. These factors will be discussed hereafter, subdivided into four parts. The first part discusses why immigrants are overrepresented in certain types of employment and in certain sectors. It focuses on the demand side of migrant labour: what pulls immigrants into certain occupations? It concentrates on the micro level and finds that working conditions are an important factor. The second part then asks how the organisation of the labour market affects employment conditions in the social care sector at the macro-level. The subsequent part discusses the impact of care policies and 'care regimes'. The fourth and final part discusses the potential impact of immigration policies and immigration histories. Each part begins by critically discussing the different positions found in the literature, and proceeds by deriving theoretical expectations that will be used to structure and orient the empirical research presented in the subsequent chapters. The expectations that concern the first research question (why migrants work in social care) are numbered as A1, A2, et cetera, in order to distinguish them from expectations regarding policy developments that are discussed in the next section and that will be numbered with B1, B2, and so on.

Employment conditions and migrant workers

Both Bettio et al. and Williams and Gavanas referred to the importance of the low costs of migrant workers, while Redfoot and Houser referred to the relatively lower prestige and working conditions associated with long-term care. How do these issues affect the employment of migrant workers? The discussion hereafter concentrates on the demand side of migrant labour. There is a range of theories explaining why migrants move, and why they go to specific countries. These point at high income inequality between regions in the world, at special links

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between certain countries, for example as a consequence of a colonial history, or at group decisions or network effects (Massey et al. 1993: 447-8). However, here the aim is not to understand why migrants move in the first place, but only why migrant workers are employed in particular sectors. As was pointed out by Redfoot and Houser (2005), neo-classical economists cannot explain why there is a demand for migrant workers in the social care sector even at times of high general unemployment. As a more promising alternative they point at Piore's dual labour market theory.

In his study of migrant labour in the United States and Europe in the decades following the Second World War, Piore found that the jobs in which migrants were overrepresented were typically unskilled, though not necessarily low paying. They had a low social status, were characterised by hard or unpleasant working conditions with considerable insecurity, had limited chances for job mobility and were 'usually performed in an unstructured work environment and involve[d] an informal, highly personalistic relationship between supervisor and subordinate' (Piore 1979: 17-19). Piore's theory is based on the industrial economy of the 1970s; but in a more recent work, Waldinger and Lichter continue along the same thread. They argue that 'there are "good jobs" and "bad jobs", and the size of the potential pool of candidates varies with the quality of a given position' (Waldinger and Lichter 2003: 9). These bad jobs are characterized by exactly the characteristics that Piore already outlined in 1979, only Waldinger and Lichter do not contend that these jobs are necessarily unskilled.

Why would migrants be willing to engage in such bad jobs? An important reason is that 'the disjuncture in living standards between developed and developing societies means that even low wages abroad appear to be generous by the standards of the home community' (Massey et al. 1993: 442). Moreover, the migrant workers in question may have no other alternative. For example, if an immigration status is valid for only one particular job, then the migrant worker has no choice but to accept the bad working conditions.

In addition to the willingness of employees to work in certain sectors, the demand from employers is also an important factor. Employers may choose to hire migrant workers because they find no native workers willing to work under similar (bad) employment conditions. Immigrants are needed 'to replace indigenous workers who will no longer do unpleasant, badly-paid unskilled jobs' (Castles and Kosack 1973: 428-9). Moreover 'employers may develop a preference for migrants because of the characteristics and restrictions attached to their immigration status' (Anderson and Ruhs 2008: 33). To this assumption I will come back below. From the above discussion the first theoretical expectation can be derived:

A1 Migrant workers are employed in "bad" jobs characterised by unpleasant working conditions, limited chances of job mobility, a personal relationship with the employer, and possibly by low pay.

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Waldinger and Lichter also suggest that economic circumstances affect the demand for migrant workers. Whenever the economic circumstances makes it possible: 'the established native workforce opts for the alternative' (Waldinger and Lichter 2003: 9), meaning they will try to find a 'better' job. Other authors, however, dispute the reversibility of the employment of migrant workers. According to Piore, once the immigration process is underway, it becomes difficult to stop (Piore 1979: 17). Once migrants start to be employed in a certain occupation this reinforces the demand for migrant labour in that sector. The presence of migrant workers further decreases the social status of a job, thereby making natives even less likely to opt for such jobs. What emerges is what Piore called a 'secondary labour market' in which a permanent demand for migrant labour exists. The demand for migrant workers has become 'structurally embedded' (Cornelius and Tsuda 2004: 9). This is in line with a 'cumulative causation' theory of migratory flows, which points at the effects of social labelling: 'once immigrants have been recruited into particular occupations in significant numbers, those jobs become culturally labelled as "immigrant jobs" and native workers are reluctant to fill them' (Massey et al. 1993: 453). Moreover, as Anderson and Ruhs argue: 'immigration targeted to address short term shortages may have had the unintended consequence of creating the conditions (such as relatively low wage, little training of domestic workers, low propensities for employers to adopt new technologies and importantly, low status) that encourage shortages of domestic workers in the long run' (Anderson and Ruhs 2008: 42). The second expectation is therefore:

A2 Demand for migrant labour increases in times of economic boom, when native workers have the opportunity to move up, and decreases in times of economic downturn.

If the demand for migrant labour in social care does not correlate (positively) with economic prosperity, then social labelling or the unintended consequences of immigration targeted to address short term labour shortages possibly led to a continuous demand for migrant labour.

Care work and labour market regimes

Above it has been suggested that employment conditions are an important factor affecting the demand for migrant workers. The next step is therefore to investigate whether certain employment conditions are typical in social care services, and how employment conditions in the social care sector are shaped. Below I start with discussing some economic characteristics of social services followed by an assessment of how the organisation of the labour market may impact upon the demand for migrant care workers. In studies of migrant care work, labour market characteristics are generally not taken into account. In this section it will be shown that these nevertheless deserve attention.

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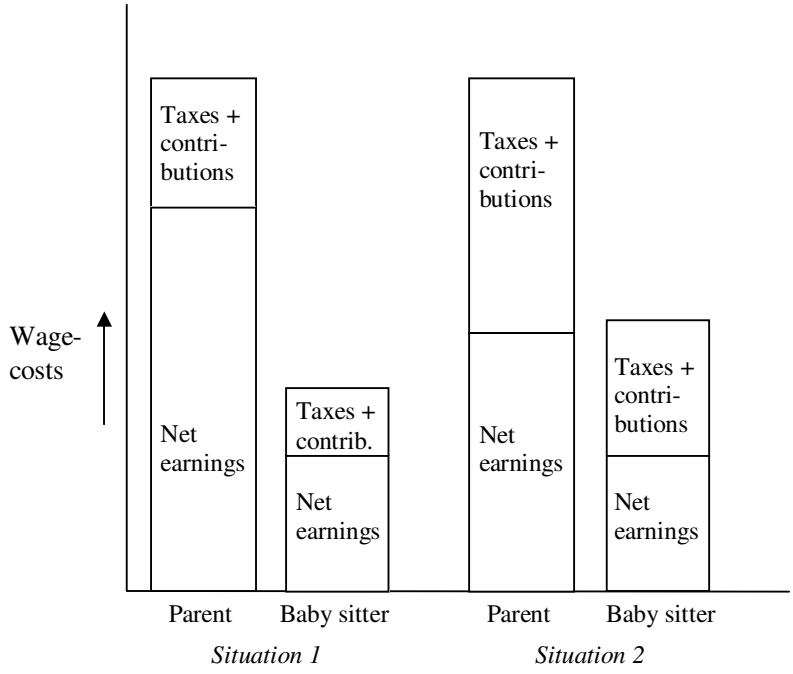
Social care is a service sector. In social care, labour is 'an end in itself', meaning that labour cannot be substituted by another process. Baumol has pointed out that social care belongs to the group of activities that, 'by their very nature, permit only sporadic increases in productivity' (Baumol 1967: 416). Yet regardless of the lack of productivity growth, wages in the labour intensive service sector increase at least partly with wage increases in other sectors. Such wage increases can be caused by competition with other sectors – childminders might decide to become car manufacturers if their wages become too low – and in some countries by income policy and trade union wage negotiations, which do not allow wages to become too dispersed. This increase of costs not accompanied by productivity increases has been called 'Baumol's cost disease'.

These high costs of (care) services make their provision on the market problematic. This is especially the case when taxes and social security contributions are high. Imagine that two employed parents have to choose between hiring a private baby sitter or having one of the parents stay at home to care for the child. It only pays-off (in economic terms) to hire a baby sitter if the net earnings of the parent are higher than the gross wage costs of the baby sitter. As is illustrated in figure 2.1, when taxes and contributions are low (situation 1), it is more likely that it pays-off to hire a baby sitter. However, when taxes and contributions are high (situation 2), only a few parents with a very high income can afford to hire a baby sitter.

Figure 2.1: Net earnings of parent compared to wage costs of baby sitter with different tax and social security contribution levels, hypothetical situations.



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The economic reasoning exemplified in the previous paragraph suggests that in countries in which taxes and social security contributions are high and – as a consequence – income inequality is relatively low, few households will choose to purchase private care services as an alternative for family self servicing (Esping-Andersen 1999: 56). Conversely, when taxes are low and income is more dispersed, more households can afford to opt for the purchase of private services. The same can be said about employment protection. When employment protection is rigid, favouring the employee, it becomes less attractive for a household to employ a baby sitter or care assistant than when employees are covered by a less rigid protection regime.

When analysing taxation, social security, income inequality and employment protection, two opposing configurations are often distinguished. Hall and Soskice, for example, identify a Liberal Market Economy in which inequality is high, taxes are low and employment protection is limited, and a Coordinated Market Economy, in which the opposite is true (Hall and Soskice 2001). The VoC literature is also concerned with how skills are obtained, how companies are organised and how they compete with others, and many other things that are less relevant for this study. To avoid confusion and in order not to pretend that I take the full set of characteristics included in a VoC approach into account, hereafter I make a distinction between a Liberal labour market regime and a Coordinated labour market regime.

As results from the discussion above, a private market for formal care services can flourish much more in a Liberal labour market regime than in a Coordinated labour market regime. These different types of labour regimes also have implications for employment conditions. In a Liberal labour market regime limited social protection and, for example, the lack of a minimum wage, allow "bad" jobs to exist. In the previous section we found that migrant workers are likely to be overrepresented in such jobs. If we link this finding with the idea that a market for formal social care is more developed in a Liberal labour market, the following expectation can be derived:

A3 In a Liberal labour market regime migrant workers are more likely to be overrepresented in formal care work.

Of course it is not the case that paid care work does not exist in a Coordinated labour market regime. On the one hand, care workers can be employed informally, thereby avoiding high taxes, social security contributions, and rigid employment protection. On the other hand, the state can step in and provide or subsidise care services. The impact of public provision or financing of care services on the demand for migrant workers is the subject of the next section.

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Care policies, care regimes and employment in social care

Williams and Gavanas found that the limited reliance on migrant care workers in Sweden was due to the country's public commitment to childcare (Williams and Gavanas 2008: 25). Bettio et al. argued that it was the lack of public provision that induced the hiring of private migrant care workers in Southern Europe. The impact of high public investments in care services on the demand for migrant workers may be twofold. First, public investments can increase the wages and improve the employment conditions of the formal social care workforce. As a consequence it would become easier to find native employees willing to work in the sector. Second, more extensive public provision may crowd out the demand for private (informal) migrant care workers. When sufficient social care services are provided at low costs for the user, there would be no need for private care workers. Below, the impact of different types of social care policies will be discussed in more detail, but at this point the following rather simple expectation can already be posited:

A4 Public investments in social care crowd out demand for all types of migrant care work.

Having said that, it should be recorded that Williams and Gavanas (2008) argued that it was not just the extent of public investments that influenced the demand for migrant care workers but also the type of investments. Bettio et al. (2006) pointed specifically at the impact of cash for care benefits. States may provide cash subsidies with which people can buy their own care services. In a study of the impact of cash for care benefits on the labour market, Ungerson et al. concluded that these impacts are 'complicated, potentially contradictory, and dependent, at least to some extent, on the funding regime adopted by the particular welfare state.' (Ungerson 2003: 383; Ungerson and Yeandle 2007).

The authors attribute different impacts of cash for care schemes to differences in the organisation of these schemes. Influential is especially 'the regulation, or lack of it, the particular cash for care policies impose on the recruitment and management of caring labour' (Ungerson 2003: 394). Highly regulated schemes require the formal recruitment and hiring of a care worker, in line with employment and social protection legislation. Less or unregulated schemes, on the other hand, may encourage the informal hiring of care workers, possibly involving more unpleasant working conditions. Earlier it was argued that migrant workers would be overrepresented in such jobs. From this we can derive the following expectation:

A5 Cash allowances, especially when unregulated, lead to a demand for migrant workers employed privately and informally.

Besides cash for care schemes, there are many more ways in which public investments in social care differ (Sipilä et al. 2003: 9). States may directly provide services by employing carers and by setting up institutions. But services can also be contracted out, meaning that states pay

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private or voluntary agencies to provide care services. Policies set eligibility criteria for recipients of care services. These may include a *means-test,* assessing the extent to which a person has the means to privately purchase or contribute to the costs of care services; a *needs-test*, assessing the need for care services due to, for example, physical or mental disabilities; and criteria for the extent to which other persons (usually family members) are required to provide care services. Each of these elements has implications for the availability of care services and the employment conditions of care workers. For example, contracting out may lead to increasing competition among care providers (Ungerson 2003: 379) and as a consequence to lower wages. A strong means-test implies that more people have to rely on privately purchased or family care.

In practice, the above mentioned elements of care policy often come in packages that are related to the provision of family care, the organisation of the labour market and to other social policies. For packages of social policies and their relation to the economy and employment, Esping-Andersen used a typology of welfare regimes, which he defined as 'the combined, interdependent way in which welfare is produced and allocated between state, market, and family' (Esping-Andersen 1999: 35). In his typology of welfare regimes Esping-Andersen distinguished three 'worlds of welfare' which could be distinguished based on stratification and decommodification (Esping-Andersen 1990). Many feminist scholars (Lewis 1992; O'Connor 1993; Sainsbury 1994; Orloff 1996), have shown that these dimensions are insufficient for understanding the organisation of social care.

When trying to understand the organisation of social care, more central is the dimension of defamilialisation, which Lister defined as 'the degree to which individual adults can uphold a socially acceptable standard of living, independently of family relationships, either through paid work or social security provision' (Lister 1994: 37). Or when referring specifically to care services: 'de-familisation concerns the degree to which women's unpaid work in the family, particularly unpaid care, is substituted for by paid labour outside the family, through public or market or third sector services' (Saraceno and Keek 2008: 8). In his 1999 work, Esping Andersen pointed out that defamilialisation can occur both through the state – when care services are publicly provided – and through the market – when care services are privately purchased (Esping-Andersen 1999: 51). Leitner (2003) added to this that a distinction should be made between, on the one hand, explicit familialism, when the state supports the caring function of the family, for example through care leaves or care allowances, and on the other hand implicit familialism, when the family cares by default, without any public support.

Several authors have tried to identify typologies or models specifically for the organisation of social care (Sipilä et al. 2003; Bettio and Plantenga 2004). A disadvantage of

these typologies is their limited relationship to other elements of welfare states and to the interrelationship between public policies and the market provision of care services. Therefore, I propose to identify a typology of social care services in line with the regime types found in the mainstream literature. The three following ideal-typical care regimes can be distinguished:

- In a *Liberal care regime*, social care is provided by the market. The only public provision of care is highly means- and needs-tested and services are usually outsourced to private agencies. The defamilialisation of care occurs through the market.
- In a *Familialistic care regime*, family members have the legal obligation to care for dependent relatives. Public care provision is only available when the family fails and are subject to a strong means- and needs-test. Services tend to be contracted out to voluntary organisations or cash benefits are paid directly to families. This type could be subdivided into explicit and implicit familialism.
- In a *Social Democratic care regime*, social care services are a universal entitlement, dependent only on a needs-test. Services are directly provided by the state and the defamilialisation of care occurs through public provision.

Care regimes consist not just of care policies. An important element – often interrelated with care policies – is also the patterns of employment. Do women and men work or stay home to care for children or older people? Do they work part-time and combine working with caring obligations? Another element to be taken into consideration is the role of culture, or ideals of care (Kremer 2007). Ideals of care affect which care services people use. There might be a mismatch between care policies and the preferences of individuals (Anttonen et al. 2003b: 171). However, in practice ideals are often closely related to policies. In countries with an ideal of family care we will usually also find policies that encourage family care. Cultures of care are an element that 'at the macro level does not vary independently' (Kohli and Albertini 2007: 6).

The three care regimes identified above should be understood as ideal types. Ideal types can be useful tools especially in relation to comparative analyses, but it is important not to confuse ideal types with categories or classifications. The problem with classifications is that 'the closer an investigation is the greater the chance that *no* case fits' (Becker 2000: 220). For example, Anttonen et al. argued that 'to suggest that nations are even preponderantly of one mode of provision or another [...] is to underestimate diversity in each country, the degree to which systems are changing and the amount of choice that people exercise in opting into or out of what is available' (Anttonen et al. 2003b: 171).

In this research project ideal types are understood in the Weberian sense as idealised constructions, used to bring order to comparisons, and not to classify the 'real world' (see e.g. Becker 2007: 265). A country's social care system may strongly resemble one ideal typical care regime, but it may also have some characteristics of several types. Moreover, care systems do not always 'fit' with other elements of a welfare state and the organisation of child and elderly care may differ to such an extent that the two resemble different ideal types. It should also be

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noted that the configuration of a care regime is not necessarily related to any political orientation. For example, a care regime that resembles the Social Democratic ideal type, could in theory be developed by Christian Democratic governments.

Because typologies can be useful heuristic devices through which the impact of characteristic 'bundlings' of institutions and behaviours may be assessed (Crompton 2006: 116), the following expectation is derived:

A6 Care regimes as a package of care policies, employment patterns and culture shape the type and extent of migrant care work.

Immigration policies and the employment of migrant care workers

The previous sections discussed the ways in which the organisation of the labour market and of social care shape a demand for migrant labour. This section investigates whether and how immigration policies impact upon the employment of migrant care workers. Bettio et al. suggested that the recurrent regularisations in Southern Europe attracted migrant workers to the country and, possibly, to employment as private care workers. That regularisation programmes constitute a pull factor for further (undocumented) immigration is often argued by those who oppose such programmes. However, evidence for this claim is scarce and based only on US studies. In the US, indeed, regularisations seem to have increased the inflow of undocumented migrants (Levinson 2005: 9).

Although most analyses of migration flows point at the importance of structural pull factors, the impact of policies should nevertheless be taken into consideration. Even if it is true that structural factors determine the demand for migrant workers, immigration policies still define the legal conditions of immigration (Guiraudon and Joppke 2001; Cornelius and Rosenblum 2005: 112). Most importantly, they determine whether migrant workers can work regularly or remain undocumented and are therefore confined to irregular work. Hollifield et al. showed that post-war US immigration policies significantly impacted the legal inflow of immigrants (Hollifield et al. 2006). Based on the potential impact of immigration policy, the following expectation can be derived:

A7 Expansive immigration policies for migrant care workers encourage their employment.

Some sociologists dispute the importance of immigration policies for shaping or stemming migration flows, because they will always be trumped by structural demands for migrant workers. Massey, for example, argued that when governments attempt to stem immigration flows by increasing border controls, they risk increasing the flows instead (see discussion in Lahav and Guiraudon 2006: 204). And similarly: 'the more restrictive the immigration policy,

the greater the number of immigrants who will simply find ways to enter the country illegally in response to employer demand' (Cornelius and Tsuda 2004: 10).

Earlier in this chapter Lister, Williams et al. were quoted suggesting that restrictive immigration policies drive migrant women into domestic and care work in the home. Similarly, Van der Leun and Kloosterman suggest that strict internal controls on irregular migrants push these migrants to seek more sheltered jobs. They found that increasingly stringent controls drove irregular immigrants into employment in private households. A private home can be a safe haven for the migrant in question because controls can usually not be carried out by authorities in such environments (Van der Leun and Kloosterman 2006: 66-7). This brings me to the following expectation:

A8 Restrictive immigration policies push immigrants into informal private employment.

While immigration policies may affect the entrance opportunities of migrant workers, they may also affect the attractiveness of employing migrant workers for employers. Andersen and Ruhs argue that:

> *[S]ome employers, especially those finding it difficult to retain workers in certain jobs, may have a demand for workers whose choice of employment is restricted, as is usually the case with migrants on temporary work permits (Anderson and Ruhs 2008: 34).*

Migrants who are dependent on work permits cannot simply decide to quit their jobs. Sometimes they are not even allowed to change employer. As a consequence, these migrant workers will be more inclined to accept working conditions that other workers find unacceptable. They are 'willing subordinates' (Waldinger and Lichter 2003: 15). Irregular migrants are even more restricted in their options:

> *Because of their very limited rights, illegally resident migrants may be perceived as displaying a better 'work ethic' and be willing to accept worse employment conditions than citizens or migrants who are legally employed (Anderson and Ruhs 2008: 34).*

This brings us to the final expectation of this section:

A9 The vulnerability of immigrants that are irregularly present or dependent on a work permit could make these migrant workers more attractive for employers.

In conclusion, in this section nine expectations were derived related to why migrants work in social care and why more so in some countries and in some types of employment than in others. These expectations are summarised in Appendix B and they are used in the subsequent chapters to guide and focus empirical research. While the case study chapters only refer to these expectations in passing, in chapter 6 their importance is examined from a comparative perspective. The next section now turns to explanations for variation in policy developments.

2.3 Understanding policy developments

The second question to be answered in this study is why some states encourage immigration into caring occupations, while others opt for alternative means to organise care services. At the beginning of this chapter, a distinction has been made between direct policy responses to migrant care work and policy developments that are indirectly related to the phenomenon. Unfortunately, there is hardly any previous research studying direct policy responses. Although most studies of migrant care work cited before discuss the importance of policies, they have not investigated why certain policy choices are made. Therefore, to understand both direct policy responses and indirectly related policy developments, we have to rely on more general research on the politics of social (care) policy and the politics of immigration policy.

Developments in social care policies and immigration policies are hardly studied simultaneously. The only notable exceptions are studies in which immigrants are seen as welfare dependents (see e.g. Bommes and Geddes 2000a; Guiraudon 2000; Sainsbury 2006). For that reason, hereafter the two bodies of literature concerning social (care) policy and immigration policy are discussed separately. Expectations regarding how to explain policy developments are derived for each of the policy fields (numbered respectively B1, B2, etc. and C1, C2, etc.).

Explaining policy developments in social care

There are large cross country difference in public policies on social care (see e.g. Lewis 1998; Anttonen et al. 2003a). What we want to understand in this section is not why these differences exist historically, but how social care policies are adapted in response to recent challenges, such as increasing demand for care services or rising costs of existing facilities.

One classical explanation for social policy development is the functional idea that social and economic changes directly result in changes in welfare state policies (Wilensky 1975). In general, such explanations are problematic because they lack a causal link between structure and policy (Myles and Quadagno 2002: 36). Moreover, in her comparative analysis of the development of long-term care policies, Morel found that the simple presence of problem pressure – stemming for example from increasing numbers of dependent elderly and the decreasing availability of informal care – could not explain the very different policy choices made (Morel 2006: 244). Nevertheless, it can be expected that problem pressure contributes to the adaptation of social care policies. This leads to the first expectation:

B1 Problem pressure – such as increasing care needs – leads to more investments in social care services.

Another classical approach is conflict theory, focusing on the political power and preferences of involved parties and interest organisations. In studies of the development of different welfare states, power resource theorists (Korpi 1983; Esping-Andersen 1990) found that a Social Democratic welfare regime emerged where left-wing political parties and trade unions were dominant, while where Christian Democratic parties and organisations were strong, a Conservative welfare regime emerged. The question is whether a similar link can be found regarding social care policies. Some authors have argued that the political power of Social Democrats would be a satisfactory explanation for 'women-friendly' policies (Esping-Andersen 1999; Huber and Stephens 2000). Others, however, have been critical of this idea. In a study of the origin of policies on childcare, Morgan found that not all Social Democratic parties and trade unions were in favour of the expansion of publicly financed care services (Morgan 2009: 61). However, Morgan did find that Christian Democratic parties played an important role in maintaining a conservative family model (Morgan 2006: 20).

Power resource theory and Morgan's study of childcare policy both focus on the developmental stage of welfare states. Even if political parties played an important role in that era, it is questionable whether they still do. In his study of the 'new politics' of the welfare state, to which I will come back below, Pierson argued that the role of political parties has been replaced by powerful groups defending the interests of welfare state recipients (Pierson 1996). Still, the impact of the party composition of governments is worth investigating. Therefore, the following expectation can be formulated:

B2 When they are in power, Social Democratic and other left-wing parties encourage public investments in social care services. Conversely, Christian Democratic and other conservative parties discourage public investments in social care services.

It could be that the direct beneficiaries of care services form a powerful political group. For example, Pierson points at the important political clout formed by older people when explaining the introduction of a long-term care insurance in Germany (Pierson 1996: 169). Other authors, however, mostly point out the political weakness of beneficiaries of care services. In their comparative analysis of social care policies Daly and Lewis found that 'there is little evidence that female carers as a lobby group have been a determining influence on policy in any country' (Daly and Lewis 1998: 13). Morel found that those actually in need of care are usually too frail to mobilise, while 'it appears that those who are still healthy have some difficulty in projecting themselves into a situation of dependency' (Morel 2006: 230). Informal caregivers, on the other hand, experience caring as a personal, moral duty, which 'offers little potential for collective mobilisation' (ibid.). Morel also found that trade unions – often an important lobby group – failed to mobilise because long-term care was not perceived to be a work related risk.

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Bonoli argues that in general 'New Social Risk' (NSR) groups – those facing risks as the result of the economic and social changes associated with the transition to a post-industrial economy – 'are notoriously politically weak' (Bonoli 2007: 512). 'The very limited power resources of the social groups that are currently most exposed to NSRs are clearly insufficient to force through the adaptation of new policies' (Bonoli 2005: 433). This brings us to the following expectation:

B3 Beneficiaries of care services – care dependents or informal carers – are politically weak and unable to influence policy outcomes.

Pierson convincingly showed that once a certain policy is in place, this creates beneficiaries with an interest in preserving the status quo (Pierson 1996; Pierson 2001a). These beneficiaries can form interest groups that become a powerful lobby for the preservation of social programmes (Pierson 1996: 147). In social care, for example, both the providers and the clients of public social care services have an interest in the continuation of social care services. There is a reverse side to this story. When policy makers want to develop a new type of social programme, for example to address public demand for care services, they find themselves 'in strong competition with demands for the preservation […] of the current level of protection provided by industrial welfare states' (Bonoli 2007: 511). Therefore, Bonoli argues, the welfare state coverage of NSRs is best in those countries in which these risks surfaced in a time in which welfare state were still expanding. Where new risks occurred early, new welfare demands 'found comparatively little competition' while they 'could count on the broad support of those actors that are generally in favour of welfare expansion, such as the Left and the trade unions' (Bonoli 2007: 511).

A reform, whether expansion or retrenchment, of social care services could also be inhibited by political structures. Various studies have demonstrated that the presence of many political veto points make the reform of existing arrangements particularly difficult (Immergut 1992; Immergut et al. 2007). These veto points may be found in the general political system, or within the specific structure of policy making on social care. In his study of developments in social care services, Alber found that the decentralisation of welfare services, their financing, and their decision making structure inhibits reforms. 'The more fragmented the decision making structure concerning social services, the more difficult it is to find consensus, and the greater the barrier to realize reforms' (Alber 1995: 144). These considerations on the impact of historical developments and political structures bring us to the last expectation on social care policy:

B4 The historical development of social care policies affects contemporary policy choices. Policy makers find it difficult to change or retrench existing social care programmes, and to introduce new programmes or investments. This path dependency is stronger when many political veto points exist.

Explaining migration policy developments

When do governments enact expansive labour migration policies for employees in the social care sector? Until now, no one has dedicated their research to answering this specific question. This section therefore considers the literature on immigration policy making more generally. Freeman (2006) has pointed out that different types of immigration policies (permanent resident visa, temporary work permits, family reunification, asylum) enhance different types of policy making. Although policies regarding family reunification and asylum might be important in setting the legal options for entering a country, here I focus only on the policies that grant temporary or permanent resident permits to migrants as employees.

Freeman argued in his early work that 'there is in general an expansionary bias in the politics of immigration in liberal democracies such that official policies tend to be more liberal than public opinion and annual intakes larger than is politically optimal' (Freeman 1995: 882-3). He explained this expansionary bias by highlighting the imbalance between the costs and benefits of migration. Those who are directly affected by immigration – 'the minority of the population competing with immigrants for scarce jobs, housing, schools and government services' – 'lack the resources to make their voice heard' (Freeman 1995: 885). The costs of immigration for the wider public generally only become apparent after immigration has taken place and the public is not well informed about these costs. The benefits, on the contrary, are confined mostly to employers involved in labour-intensive industries. In a comparative work on immigration policy in Europe, Menz contends that:

> *Notwithstanding persistently high general unemployment rates and a political climate influenced by often hostile public opinion [towards immigration] employer associations lobby governments for more permissive and pragmatic labor migration policy either openly or, given the less than amiable context, somewhat hidden from public scrutiny (Menz 2009: 2)*

According to Freeman, the state, in turn, 'will respond to the organized pressure of groups favourable to immigration, ignoring the widespread but poorly articulated opposition of the general public' (Freeman 1995: 885). Freeman developed his argument even further by arguing that 'there is a strong tendency [...] for the major political parties to seek a consensus across the political spectrum that has the effect of taking immigration conflicts off the agenda' (Freeman 1995: 884). He concluded that 'the typical mode of immigration politics, therefore, is client politics, a form of bilateral influence in which small and well-organized groups intensely interested in a policy develop close working relationships with those officials responsible for it' (Freeman 1995: 886).

It is often assumed that trade unions would oppose expansive immigration policies, because they represent the losers of immigration (Castles and Kosack 1973). However, recent

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studies found that trade union leaders 'have come to believe that restrictive policies do little more than force immigrants into a precarious legal and economic position, which ultimately undermines the wages and working conditions of all workers' (Watts 2002: 2). In his more recent work, Freeman added that sector specific policies will depend on whether immigrant workers are complementary to or a substitute for native workers (Freeman 2002). When migrant workers are complementary to native workers, employees and trade unions will not have strong objections against expansive policies. By contrast, where migrant workers are substitutes for native employees, domestic workers will be strongly opposed to immigration. In the latter case they are more likely to organise and lobby against expansive policies. From this discussion of the role of interest organisations in immigration policy making we can derive the following expectation:

C1 Strong employers' organisations encourage the government to enact expansive immigration policies. The role of trade unions is more ambivalent and might depend on whether migrant workers replace or supplement native workers.

A major criticism of Freeman's interest based argument is the total absence of politicians and political parties (Brubaker 1995). Other scholars have taken the role of political parties more seriously. It is often assumed that right-wing parties in general take a more anti-immigrant stance than left-wing parties. While right-wing parties would be concerned with conservative voters and identity related issues, left wing parties would be inclined to support migrant workers because of a feeling of solidarity with them and because they are potential voters (Lahav 2004; Messina 2007: 209). However, other scholars have pointed at the potential political cleavages the immigration issue brings about in both centre-left and centre-right parties. Within left-wing parties an anti-immigrant sentiment may be voiced by protectionist unions and by the native working-class population which fears losing their jobs. Within right-wing parties pro-immigrant voices stem from business organisations that benefit from migrant labour (Perlmutter 1996: 377; Schain 2008: 467-8). Hence, it is difficult to formulate an expectation regarding the impact of political parties:

C2 When they are in power, left-wing parties may be more inclined to enact expansive immigration policies, but both the left and the right are internally divided by the issue of immigration.

After the recent successes of extreme right anti-immigrant parties, the influence of these parties can no longer be disregarded. According to Schain, the radical right in Europe has been 'a major force in constraining and shaping the way immigration policy was developed in many countries' (Schain 2006: 270). The breakthrough of radical right parties can result in a realignment of other parties regarding the issue of immigration. Some have argued that centre-right parties are particularly prone to shift to a more anti-immigrant position. Yet others pointed out that 'progressive' parties are 'under as much, if not more, pressure from populist entrepreneurs

aiming to steal their voters' (Bale 2008: 320). Moreover, the presence of radical right parties can influence the policy agenda, placing the aim of curbing immigration at the centre of political debate. So, even if radical right wing parties are often not included in governing coalitions:

C3 The electoral strength of populist or radical right parties leads to more restrictive immigration policies.

In her study of the social rights granted to immigrants, Guiraudon points out the importance of policy venues, defined by Baumgartner and Jones as the 'institutional locations where authoritative decisions are made concerning a given issue' (Baumgartner and Jones 1993: 32). Guiraudon claims that: 'foreigners are more likely to gain rights when reforms are not highly salient in public opinion and the media, when there is no open debate in the electoral arena' (Guiraudon 2002: 138). Instead, migrants would be most likely to gain rights in a technocratic, bureaucratic or judicial policy venue. In theory, the same could also hold for immigration policies concerning migrant care workers:

C4 When decisions on immigration policies are made in technocratic, bureaucratic or judicial venues and there is no open debate in the electoral arena, it is more likely that these immigration policies are expansive.

Finally, the timing of immigration, as the timing of new social risks discussed in the previous section, could affect current policy choices. In European states with a history of postcolonial and guestworker migration, contemporary politics relating to immigration are 'haunted by the mistakes, failures, and unforeseen consequences of the guestworker era and by the social conflicts associated with the new ethnic minorities created during that time' (Freeman 1995: 890). Southern European 'new countries of immigration', on the other hand, have not encountered such negative experiences, and therefore 'public opinion has not been a major influence on policy' (ibid.: 895). This idea has been found to be outdated, because public opinion has in fact started to play an important role in Southern European immigration policies. Nevertheless, different historical experiences with immigration might affect contemporary policy choices:

C5 Historical experiences with immigration affect contemporary policy choices. In particular, negative historical experiences lead to more restrictive immigration policies.

2.4 Method: a comparative case study analysis

The theoretical discussions in this chapter have shown that there are a large number of factors that might affect migrant care work and the policy responses to this phenomenon. The aim of this study is not to confirm or disconfirm any particular theory, but instead to explore which causal mechanisms are at work. For this exploratory aim, a case oriented comparative method is

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applied. This method can be called a comparative case study approach (Agranoff and Radin 1991).

A case study is here understood as 'an intensive study of a single unit for the purpose of understanding a larger class of (similar) units' (Gerring 2004: 342). Case studies are particularly useful for exploratory research because they allow one 'to peer into the box of causality' (ibid.: 248). The central aim of case study research is to identify within each case the causal mechanism that leads to a certain outcome. George and Bennett call this aim 'process tracing':

> *In process tracing, the researcher examines histories, archival documents, interview transcripts, and other sources to see whether the causal process a theory hypothesises or implies in a case is in fact evident in the sequence and values of the intervening variables in that case (George and Bennett 2005: 6).*

Even when analysing only one case, there is always an inherent element of comparison. This can consist of a comparison within the case. For example, the situation before and after a certain even can be compared or smaller units within a case, such as individual level data, can be investigated comparatively. A comparison can also consist of implicitly comparing the case with other cases. One could, for example, compare employment levels in one country with the EU average. As Gerring put it: 'additional units always loom in the background' (Gerring 2004: 344).

Tilly terms this kind of implicit comparison an 'individualizing strategy', the aim of which is to understand what makes one case special. For example, when looking at the labour market participation of Dutch women, we can see that many work, and that some work fewer hours than others. But it is only in comparison with other countries, or with an OECD average, that we discover that what makes the Dutch case special, is the very large percentage of women working part-time. Comparisons are necessary to 'bring out the distinctive features' (Tilly 1984: 83) of one particular case. In the separate case studies that will be presented hereafter, the individualizing strategy is used to understand what makes each of the countries special.

The comparative case study approach is not just based on separate case studies, but also on a comparison of these cases. Comparative analyses often apply a most similar or most different systems design, applying respectively Mill's method of difference or method of agreement (Ragin 1987). In a most similar systems design, cases are chosen in a way that all potentially relevant variables are equal, except for the dependent variable and – hopefully – one independent variable which would then explain the variation in the dependent variable. In a most different systems design, two cases are selected so that they are different in all relevant variables, except for the dependent variable and – again hopefully – one independent variable.

Most different and most similar system designs are problematic for both fundamental and practical reasons. One fundamental problem is that such system designs presuppose a

deterministic instead of a probabilistic relationship between variables. Something is a cause or not, but there is no room for chance, error, or gradualism. Moreover, the methods of agreement and difference are both very sensitive to an omitted variable bias and do not allow for interaction effects. Therefore, Lieberson concludes that Mill's procedures cannot be applied to small-N studies, because such studies cannot meet 'the assumptions essential to causal analyses generated by such procedures' (Lieberson 1991: 117). Besides these fundamental problems there is a practical problem. To set up a most similar or most different system design requires a thorough knowledge of the phenomenon and potentially relevant independent variables before selecting specific cases. Only then can one be sure to select cases in such a way that they meet either of Mill's methods' requirements. Since – until recently – very little was known about migrant care work and the policy responses to it, it was impossible to select cases on these grounds.

Because of these fundamental and practical problems, this research project does not apply a most different or most similar systems design. Instead, cases have been selected which exhibit a considerable degree of variation on the two core dependent variables: the importance of migrant care workers and the policy developments related to the phenomenon.

Instead of relying on a most similar or most different systems design, two strategies of comparison, as defined by Tilly, are applied. First, a universalizing strategy looks for one or several causes that are universally applicable to all cases. Second, a variation-finding comparative strategy tries to find 'a principle of variation in the character or intensity of a phenomenon by examining systematic differences among instances' (Tilly 1984: 82).

It should be recognised that by its nature, case study research involves a certain degree of subjectivity. It is always the researcher who has to decide which factors to take into account and how to interpret the observed processes. This subjectivity is undoubtedly present in this study. However, according to Gerring, this could be turned into a virtue: 'the very "subjectivity" of case study research allows for the generation of a great number of hypotheses, insights that might not be apparent to the cross-unit researcher' (Gerring 2004: 350).

The nation state was chosen as the main level of analysis for this study. The reason for this choice is that most policies regulating the phenomenon of migrant care work are still set at the national level. In most countries, policies regarding labour migration are entirely negotiated and decided at the national level. Care policies are sometimes administered at local or regional levels, but the framework for a care system, including most important budgetary decisions, is set nationally.

The empirical data on which this research is based include descriptive statistics, policy documents, parliamentary debates, and newspaper articles. In addition, 32 interviews were

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carried out with a total of 37 policy makers, interest group representatives and experts. A list of all interviewees can be found in the appendix. To understand the processes at work within each of the countries, micro-level data are used – where possible. Unfortunately, the data used differ by country. Most importantly, different types of statistical data are used to describe the importance of migrant care work. Sometimes, no statistical data were available at all. The analysis then relies only on interviews and secondary sources and as a consequence the evidence is only sketchy. Nevertheless, as will be further discussed in each of the case study chapters, a clear and consistent picture emerges of the importance of migrant care workers in each country.

Finally, the two research questions that are central to this research project, one concerning the prevalence of migrant workers and the other regarding policy reactions to this phenomenon, are strongly interrelated. Therefore, there is potentially an endogenous effect at work. Policy developments are likely to affect the prevalence of migrant workers, which will in turn affect policy reactions. I do not consider this reciprocal relationship to be a problem. On the contrary, the aim is to understand how exactly this interrelationship works. How do policy choices affect the employment of migrant care workers? And how does the prevalence of migrant workers affect policy choices? Only when we understand this interrelation, we can fully understand cross country variation or convergence.

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3 ITALY: PRIVATE MIGRANT CARE WORK AS A CONVENIENT SOLUTION

> *In our country, the situation of an older person is still strongly maintained through family relations, which are more solid than in other countries. This bond should be encouraged and nourished. We think about badanti [migrant elderly carers], emerged spontaneously, as requested by families. Not only and not primarily because of a lack of public provisions, but due to the call for a flexible service, more adapted to the needs of families, controlled and run directly by relatives (Ministero del Lavoro 2009: 33, author's translation)*

In Italy, the importance of migrant care workers has become so clear that observers have spoken about 'the transition from a 'family' to a 'migrant in the family' model of care' and a 'complete overhaul of the long-term care sector' (Bettio et al. 2006). These migrant workers are directly employed by families. Most prominent are elderly carers – the so-called 'badanti'[6]. Less numerous are the migrants caring for children as baby-sitters. In this chapter it is shown that the importance of migrant workers should be understood in the context of a highly Familialistic care regime, in which families had to find their own solution for their care needs.

Meanwhile, Italy, like many other European countries, has experienced growing anti-immigrant sentiments which are voiced by right-wing political parties such as the Lega Nord. Immigrants have often been stigmatised as criminals. Nevertheless, as the opening quote of this chapter suggests, migrant care workers were generally welcomed. The 'migrant in the family' model of care has largely been endorsed by public policies. While public provision of care services has remained limited, immigration policies have allowed for the mass entrance of foreign carers. For example, a provision in the 2002 Bossi-Fini Act, named after Umberto Bossi, one of Italy's most anti-immigrant politicians, allowed for the regularisation 316,000 domestic and care workers. In addition, special immigration quotas were set for migrant domestic and care workers.

Considering that the phenomenon of migrant care work is so well known and visible in Italy, there is also a substantial body of literature on the topic. There are numerous studies of the importance of migrant domestic and care workers in Italy (for example: Sarti 2004; Colombo 2005; Hillmann 2005) and about the characteristics and experiences of migrant carers (for example: Andall 2000; Castagnone et al. 2007; Degiuli 2007; Torre 2008). In addition, there

[6] The word *badante* (plural: *badanti*) is a neologism that derives from the verb *badare* (to take care). It became widely used for the first time in 2002. Although the word can sometimes be found in official documents, its use is mostly informal. The term refers to private (usually foreign) care assistants who care for elderly or other dependent persons.

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have been a number of surveys of migrant domestic and care workers (Iref 2007). Finally, there are several authors who have investigated the role of migrant workers within the Italian care system and welfare regime more generally (Sciortino 2004; Bettio et al. 2006; Da Roit 2007; Gori and Da Roit 2007; Scrinzi 2008). More than the subsequent case study chapters, this chapter can therefore rely on a relative wealth of available information when describing and explaining the employment of migrant care workers. What is still mostly missing, however, is research on the policy responses to this phenomenon. No research projects have focused explicitly on why immigration policies have been so encouraging for migrant care workers. Studies of the way in which the presence of migrant workers has an impact on public investments in care services is also lacking, although it has been suggested that the availability of cheap migrants hinders the development of agency-based services (Bettio et al. 2006: 274; Lamura 2008). In the area of policy developments related to migrant care workers, this chapter therefore adds much new material.

Besides the numerous secondary sources, the Italian case study relies on 10 expert interviews with policy makers and interest group representatives. Most interviews were carried out in Italian. Quotes from these interviews were translated by the author. In addition, some family survey data are analysed. Below, the first section (3.1) sets out the context of the Italian welfare state, labour market, developments in child and elderly care, and a short history of immigration. The second section discusses the importance of migrant care workers, followed by the third section which attempts to explain the large presence of migrant care workers. Section 3.4, finally, discusses the recent developments in care and migration policies in response to migrant care work.

3.1 Care and migration in Italy

How can we explain the increasing reliance on privately employed migrant carers, especially in elderly care? Before examining in detail the characteristics of migrant care work in Italy, this section sets out the context within which we should place the Italian developments.

Labour market, employment protection and the Italian welfare state

In the decades following World War II, the Italian welfare state was expanded. Social policies strongly favoured male breadwinners. Combined with rigid employment protection regulations the result was 'the hyper-protection of the already employed worker' (Ferrera and Gualmini 2000: 190). Unemployment benefits and pensions were generous for those who had been in

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continuous employment (ibid.). This system of social protection of the male breadwinner was completed in the 1970s and hardly changed in the 1980s. In line with the male breadwinner model, female employment rates were very low. As was visible in table 1.2 in the introduction, in 1970 only 27 percent of all women in Italy aged between 15 and 64 were employed, compared to 39 percent on average in the EU-15.

In the 1990s, a number of reforms took place. These included several pension policy reforms, for example the 1992 Amato reform in which the legal retirement was increased with from 60 to 65 for men and from 55 to 60 for women. The 1997 Treu reform of employment legislation introduced the option of temporary employment, which was prohibited until then (Ferrera and Gualmini 2000: 195). At the same time, women's employment rate increased gradually to 37 percent in 1998 (compared to 52 percent in the EU-15, see table 1.2), and by 2008 to 47 percent in Italy (and 60 percent in the EU-15). With the increasing employment rates, the share of women employed part-time also increased from 22 percent of all employed women in 1998 to 31 in 2008. The increase that took place in the 1990s and 2000s occurred to a large extent as a result of more people being employed in temporary and part-time jobs (Schindler 2009: 72). While the Treu reform contributed to more employment opportunities, it also increased the fragmentation of the Italian labour market and the country's social protection system. The 'insiders', employees with full-time and long-term contracts, are usually well protected against dismissal and can count on generous unemployment benefits. The 'outsiders', on temporary and part-time contracts and the long-term unemployed, lack such extensive protection (Schindler 2009).

While pensions and unemployment benefits are very generous for the 'insiders' of the Italian labour market, the Italian welfare state has no comprehensive social assistance system that includes a guaranteed minimum welfare level for all citizens (Leibfried 1992; Ferrera 1996). Instead, it is the family that is primarily responsible for providing welfare for financially or physically dependent family members (Saraceno 1998). According to the civil code the group of kin that can be required to provide income support includes spouses, children, parents, siblings, sons and daughters in-law, and parents in-law (Naldini 2003: 122). The strong familialism of the Italian welfare state does not result in policies supporting the traditional family (Saraceno 1994: 61). Instead, it is a form of implicit familialism (Leitner 2003, see the discussion of care regimes in chapter 2). In Italy there is a universal health care system, similar to the British National Health Service (Ferrera 1996). In social care, by contrast, the role of the state in the provision of services is historically limited.

Elderly care

Traditionally, the main providers of care services for the elderly – besides the family – have been voluntary organisations related to the Catholic Church. In 1890, following the 'Legge Crispi', these private organisations were brought under some public control. They were called IPABs (Instituzioni di Pubblica Assistenza e Beneficienza: Institutions for Public Assistance and Wellbeing) and received some public funding. Until 2000 the Legge Crispi had been the main law regulating social services.

The Christian Democrats (Democrazia Cristiana, DC), who dominated politics until the early 1990s, strongly supported the Catholic ideal of a subsidiary role of the state vis-à-vis the family and, in relation to that, the reliance on voluntary church-related organisations rather than public provision of services (cf. Saraceno 1998; Naldini 2003). In the 1948 Italian Constitution, the responsibility for social assistance and care was delegated to regional and local authorities. In the absence of national guidelines, care services have developed unevenly in different regions. Substantial variation existed and still exists between Northern and Southern regions, and between regions run by Christian Democrats – and the Italian centre-right parties that have taken their place since the mid 1990s – and left-wing parties. In general, the limited funding local governments had available meant that the provision of elderly care services remained largely confined to voluntary and non-profit organisations throughout Italy (Fargion 2000: 76-7).

In the late 1980s, the high costs of frail elderly people occupying hospital beds put long-term care for the elderly on the national political agenda (Trifletti 1998: 183). In the following years several reform plans were introduced. However, due to the lack of financial means available, these plans only reinforced regional policy initiatives, thereby increasing regional differentiation. Overall, the initiatives did not really alter the scarcity of care services in quantitative terms (Da Roit et al. 2007: 658). Elderly care is still heavily means- and needs-tested. 'The state will not assume the financial burden for the family/kinship dependent members until the means of all these kin, who are legally responsible for maintenance, have been thoroughly investigated' (Naldini 2003: 123). As a result, publicly provided or financed care services constitute only a last resort when all other options for care are exhausted (Da Roit 2007: 252).

The continuing importance of family ties is also reflected in the living arrangements of older people. Off all Italians aged 80 and over, 42 percent lives together with or in the same building as a child. By contrast, this applies to only 3 percent of Dutch people in the same age group (see Appendix table A-1). Compared to other European countries, Italian dependent

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elderly rely more heavily on informal unpaid care, mostly provided by relatives that either live within the household or nearby (see Appendix table A-2). Meanwhile, the availability of publicly funded services is limited. Table 3.1 shows the use of publicly provided or financed services in different regions. As can be seen, there is a large regional variation. Of the elderly population, 1.4 percent in the north-east is in publicly funded residential care, while only 0.2 percent of the elderly population in the south uses such services. The totals for Italy are lower than the number presented in table 1.5, because the latter includes also more medical forms of care (nursing homes and long-stay beds in hospitals). But even when these other structures would be included, the number of Italian elderly living in an institutional care facility (2.1 percent) is still low in an international perspective. Table 3.1 shows that home care coverage is between 1 and 2 percent in all regions, except for Sicily and Sardinia where it is 3.5 percent.

Table 3.1: Percentage of elderly (+65) using publicly funded social care services, 2003

Region	Residential care[1]	Home care[2]
North-west	0.9	1.6
North-east	1.4	1.9
Centre	0.9	1.4
South	0.2	1.5
Islands	0.5	3.5
Italy	0.8	1.8

Source: Ministero della Solidarietà Soziale (2006: 39, 52). Data refer to 'servizi sociali territoriali'.
[1] 'strutture residenziali'.
[2] 'assistanza domiciliare'.

Compared to the limited use of publicly funded services, many more frail elderly can benefit from an attendance allowance (*Indennità di accompagnamento*). This cash allowance was established in 1980. It was at first only meant for disabled adults, but it was soon expanded to include the frail elderly. The benefit is needs-tested – paid to those who are unable to work and in need of constant care in order to carry out every day activities – but not means-tested. It is paid at a flat rate – €465 per month in 2008 – and there are no requirements or controls on how it should be spent. The number of beneficiaries of the allowance has increased continuously over the past two decades. In 2007 it was paid to a total of 1.15 million elderly, or 9.8 percent of the Italian population aged over 65[7]. A simple comparison between this percentage and the data on the use of care services presented above, demonstrates that only a small part of those people

[7] Figures are for 2007, www.inps.it, Osservatorio sulle Pensioni

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receiving an allowance due to their dependence on constant care can also rely on residential or home care services.

Child care

In addition to the family's role in elderly care, the family is also central to the organisation of childcare, especially for children aged 0 to 2. Not only parents, but also grandparents play an important role. Public provision for the very young was, for a long time, kept away from the public agenda. The male breadwinner model, with a housewife staying at home with the children, was an ideal strongly supported by the dominant Christian Democrats. The ideological support for care provided directly by mothers was so strong that even the Italian Communist Party in opposition did not dare to openly challenge this model of care. There was very little room for an open debate on the family, the representation of women in work and childcare (Bimbi and Della Sala 2001: 118).

Nevertheless some policy changes with educational objectives were approved in the late 1960s and early 1970s. A 1968 law expanded public pre-schools for children aged three to six. These children obtained the right to attend public pre-schools ('Scuola Materna') free of charge. Although the pre-schools were not obligatory, they quickly became very popular. Another law enacted in 1971 made local and regional governments responsible for establishing a childcare system for the very young. In the debate preceding this law, the equal opportunities of women were pitted against the rights of children (Saraceno 2007: 248). As a result, day care centres ('asili nido') for the very young never became a right for people to avail of, and local governments are not obliged to set up public day care facilities.

Little has changed in the organisation of childcare in Italy since these two laws. Most children aged three to six attend pre-schools free of charge. As table 1.5 in the introduction showed, 91 percent of Italian children in this age group attend a formal childcare arrangement. The pre-schools are managed by the Ministry of Education and administered by local authorities. While pre-schools were not intended to function as full-day childcare facility, they usually run until 4pm. Therefore, they cover a substantial part of the childcare needs of working parents. Nevertheless, the percentage of Italian mothers with children aged between 3 and 5 that are formally employed is only 52 percent, which is well below the European average of 66 percent (see table 1.2 in the introduction).

Childcare for the 0 to 2 year olds is entirely organised by local communities. Communities can decide on eligibility criteria and set parental contribution rates. For the year 2007-2008 these contribution rates varied between an average of 146 Euros a month in Rome to

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over 500 Euros in some cities in the north (Cittadinanzattiva 2008: 6-7). The coverage rate of public childcare services also varies greatly. According to government data (see table 3.2), in 2003 13.6 percent of all children aged zero to two in the north-east attended a public or publicly funded day care centre, the percentage was only 2.4 in the south. On average 9.1 percent of Italian children aged between 0 and 2 attended a public day care facility. This figure differs substantially from the 27 percent coverage rate reported in table 1.5 in the introduction. Partly, this difference can be explained by the existence of private day care facilities.

Table 3.2: Percentage of children aged 0-2 in public day care facilities by region, 2003

Region	Percentage in public day care
North-west	12.9
North-east	13.6
Centre	11.8
South and Islands	2.4
Italy	9.1

Source: Ministero della Solidarietà Sociale (2006: 29)

Immigration

Until the 1980s more people left Italy than arrived in the country. Italy has a long history of emigration, especially between the 1890s and 1914. In the first three decades after World War II emigration continued, while millions of Italians also migrated from the south and rural north to Italy's industrial centres (Ginsborg 1990: 219). In 1981 population inflows were for the first time larger than outflows, due to both return migration and new arrivals (Calavita 2004: 345). In the past two decades immigration has increased rapidly and in the 2000s Italy had become one of the main immigrant-receiving countries in Europe.

After increased political and media attention, Italy introduced its first comprehensive immigration law in 1986. It addressed immigrants as workers who competed unfairly (= illegally) with native workers (Zincone and Caponio 2006: 2). The law set conditions for admission of immigrants and for the regularisation of migrants already living in Italy. As a consequence, 105,312 irregular immigrants were regularised (Veikou and Triandafyllidou 2001: 5). That the law functioned inadequately became apparent due to increasing unrest, especially in the south of Italy. In reaction, a new migration law (known as the Martelli Law) was passed in

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1990. The new law aimed to give immigrants a decent life, while immigrant inflows were to be drastically decreased. The law also allowed for a new regularisation, with 234,841 irregular immigrants taking advantage of this new opportunity (Zincone and Caponio 2006: 3). The 1990s were nevertheless again characterised by new inflows of migrants, especially from Eastern Europe due to the collapse of the Communist regimes, but also from South America and various Asian countries. After a number of ad hoc provisions, new legislation followed in 1995 (known as the Dini Decree). The law again allowed for regularisation of certain immigrants, with 248,501 irregular immigrants applying (Zincone and Caponio 2006: 4).

The bulk of the legislation that currently regulates immigration into Italy stems from two major reforms, which will be discussed in more detail below. The first one is the 1998 'Turco-Napolitano' Act (40/1998). The second is a reform of the 1998 law, better known as the 'Bossi-Fini' Act (189/2002). The Turco-Napolitano Act contained some very strict measures on undocumented immigrants, setting up special detention centres for arrested immigrants that were to be expelled. At the same time the law allowed for yearly immigration quotas, a job-seekers permit[8], and supportive measures for immigrants already living in Italy. A regularisation of irregular residents was enacted after the main law through a 'Corrective Decree' (no. 380 of 16 October 1998). It allowed for the regularisation of 220,000 undocumented immigrants.

The Bossi-Fini Act further tightened the criteria for legal entrance and expanded the possibilities for detention and expulsion of irregular immigrants. Job-seeker permits were abolished, but the yearly immigration quotas to be set by the government were maintained. The act included a regularisation specifically targeted at domestic and care workers, resulting in some 316,000 domestic and care workers obtaining a work permit out of a total of almost 647,000 regularised migrant workers.

The stock of officially resident foreigners increased rapidly from 1.3 percent of the total population in 1995 to 6.6 percent in 2008 (see introduction, table 1.3). Foreign born workers formed more than 10 percent of the Italian labour force in 2008, a percentage that is around the EU-15 average (see Appendix table A-3). In 2008, free movement within the EU was the most important way in which immigrants gained permanent access to Italy (see Appendix table A-3). Family reasons were the second most important way in which a resident permit is acquired, followed by work reasons in third place. Much less numerous are the permits based on humanitarian grounds (only 6,400 in 2006) (OECD 2008a: 253).

As can be seen in table 3.3, in 2007 the largest group of foreign residents consisted of Romanians. This group had grown explosively in the preceding years, from only around 8,000

[8] A limited number of immigrants could enter the country with the goal of searching employment, without having arranged anything in advance.

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Romanians living in Italy in 1994 (Calavita 2004: 350), to 625,000 in 2007. The second largest group was formed by immigrants from Albania, followed by Morocco and China. The fifth place is taken by Ukrainians. Strikingly, 80 percent of the regulated Ukrainian immigrants present in Italy are female. Since Ukrainians are strongly represented among domestic workers, as will be further discussed hereafter, a large proportion of these women probably work in domestic services. In addition to these formally resident migrants, the number of migrants living in Italy irregularly remains large. In 2009, Caritas estimated that one million immigrants were irregularly residing in the country[9]. Two thirds of all foreigners in Italy are believed to have lived in the country irregularly for at least some time (FIERI 2006).

Table 3.3: Foreigners resident in Italy, December 2007

Country of origin	Number of immigrants	Percentage women
Romania	625,278	52.9
Albania	401,949	44.7
Morocco	365,908	40.8
China	156,519	47.3
Ukraine	132,718	80.4
Philippines	105,675	58.5
All	3,432,651	…

Source: Caritas/Migrantes (2008)

3.2 Towards a 'migrant in the family' model of care

Migrant workers in private care

In 2007, one Italian newspaper ran the headline 'At home two million domestic workers'[10]. According to the newspaper, of these two million, 80 percent were foreign. Another heading declared that 'One in ten families hires a *badante*'[11] (a private care assistant). These headings not only suggest that migrant domestic and care work is widespread in Italy, they also underline that it is a well-known phenomenon.

[9] 'Clandistini in Italia sono un milione', *Corriere della Sera*, 10/08/2009
[10] 'In casa due milioni di colf', *Il Sole 24 Ore*, 2/04/2007.
[11] 'Una famiglia su dieci ha la badante', *Corriere della Sera*, 12/08/2009.

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Migrant domestic work is not entirely new in Italy. A census held in 1978 estimated that between 70,000 and 100,000 migrant women were working as home help, with many coming from Cape Verde, Eritrea (Andall 2000: 57) and the Philippines. The Catholic Church played an important role in recruiting these women into working in domestic services in Italy. Several things changed in the 1990s and 2000s in migrant domestic work compared to the 1970s. First, the magnitude of the phenomenon has grown strongly. Second, the type of work migrants carry out has changed. While home helps (*collaboratrici familiari* – colf for short*)* have existed for a long time, migrants have started to work more often as personal care assistants ('*badanti*') for dependent elderly. Third, in recent years migrant domestic and care workers have come from different regions, most notably from Eastern Europe.

Although the press clearly suggests that migrant workers have flooded the Italian care sector, it is not easy to know how many migrants work as care assistants or baby-sitters. Since the job takes place entirely within the private sphere it is difficult to control or monitor. However, due to repeated regularisations and the issuing of work permits, these migrant workers have at least partly emerged out of the grey sector. The National Social Security Institute (INPS) reports the number of Italian and foreign domestic workers employed formally by Italian families. Unfortunately, the INPS does not distinguish between different types of domestic work, i.e. between home helps, babysitters and care assistants. Nevertheless, the data do reveal some informative trends.

As figure 3.1 shows, the number of foreign domestic workers legally employed in Italy has increased enormously over the past decades. In 1991 there were 35,740 foreigners formally registered as domestic workers, forming 17 percent of all domestic workers. By 2007, 464,033 migrants were employed, meaning 78 percent of all domestic workers. A closer look at the fluctuations of the numbers of registered foreign domestic workers shows a distinct peak in 2002. This peak is related to the regularisation that was included in the Bossi-Fini Act of 2002, which will be discussed at length in the second half of this chapter. In order to be eligible for regularisation, the migrant domestic or care worker had to be regularly employed, meaning that her or his employer had to pay social security contributions. As mentioned before, the number of employers applying for a regularisation of their domestic worker was enormous. As a consequence, the number of workers paying social security contributions, and therefore being registered, also increased strongly. In the following years, the numbers decreased again gradually, because migrant workers relapsed into irregularity. At the end of 2006 a new government expanded the quota of available work permits for that year. In practice they granted work permits to almost all applicants, including those that were actually already living and

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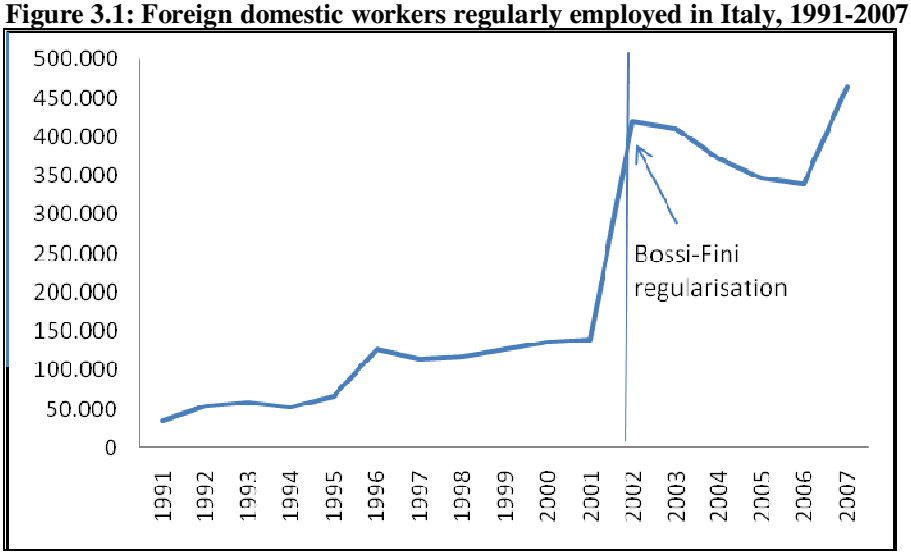
working in Italy. This 'hidden regularisation' explains the second surge in the number of domestic workers regularly employed in 2007.

Figure 3.1: Foreign domestic workers regularly employed in Italy, 1991-2007



Source: 1990 – 2000, Sarti (2004); 2001 – 2007, INPS (2009)

Before discussing the role these foreign domestic workers play in Italian families, it is useful to have a look at some of their demographic characteristics. According to the official Inps data (see table 3.4), more than 60 percent of all registered migrant domestic workers in 2007 came from Eastern Europe. Until the 1990s, domestic workers originated primarily from Asia (especially the Philippines), South America (Peru), and Africa (Cape Verde, Eritrea). However, in the 1990s the sector was largely 'overtaken' by migrants from Eastern Europe (Romania) and the former Soviet Union (Ukraine). In 2002 Ukrainians and Romanians accounted for almost half of the regularised domestic workers, followed by workers from Ecuador, Poland, Moldova and Peru (Iref 2007: 9-14; Istat 2007: 52). Strikingly, in all of these countries the majority of citizens are Catholic or Orthodox Christian. A survey of migrant domestic workers in Italy confirmed that most adhered to a Christian religion (Iref 2007).

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Table 3.4: Foreign domestic workers by zone of origin and percentage of women among domestic workers from different origins, 2007

Zone of origin	As % of all foreign domestic workers	Women as % of all[1]
Eastern Europe	61	95
South America	11	90
Philippines	11	75
Africa	7	73
East Asia	6	47
Italy	-	95

Source: INPS (2009)

[1] Women as percentage of all (foreign) domestic workers from the same region of origin.

The large majority of domestic workers are female. There is, however, a remarkable difference between nationalities. While women form 95 percent of all Italian and Eastern European domestic workers, only 47 percent of all East Asian domestic workers are female. It is also striking that the share of men peaked with the 2002 regularisation, when men formed 17 percent of all foreign domestic workers. By 2006, this percentage had decreased to only 12 percent. In other words, the number of registered male foreign domestic workers decreased by 43 percent between 2002 and 2006, compared to a decrease of only 14 percent of female foreigners. Explanations for this quick decrease of male workers will be discussed later.

The figures presented so far only concern regularly employed domestic workers. In addition to these regular employees there is also a substantial group or irregular domestic and care workers. A survey carried out in 2007 among 1000 migrant domestic workers showed that most of them, regardless of their nationality, entered Italy on a temporary tourist or student visa. The great majority of the sample had been living in Italy irregularly for some time. While many had been able to regularise their status at the moment they were interviewed, a quarter of the respondents still resided in Italy irregularly (Iref 2007). Estimating the total number of domestic and care workers employed in Italy remains problematic. Circulating estimates of the total number of migrant care workers (*badanti*) range from 650,000 to over one million (Spano 2006; Da Roit et al. 2007: 665; Savioli 2007: 32). However, the empirical base for these estimates is often unclear or based on small surveys carried out in only one city. Therefore, their reliability is questionable.

In a 2003 household survey (*Indagine Multiscopo Sulle Famiglie, 2003*), respondents were asked explicitly whether they hired a home help (*colf),* baby-sitter or care assistant

(badante) and whether these were Italians or foreigners[12]. The results are reported in table 3.5. As can be seen, 6.2 percent of all households in the survey reported to be hiring a home help and one third of these home helps were foreign. About one percent of families reported to hire a babysitter or elderly carer. While less than one in every five babysitters was foreign, almost half of all elderly carers were foreign.

The last column of the table shows the estimated numbers of families that hired a foreign domestic worker in 2003. According to the weighted survey data 104,000 Italian families hired a foreign worker to care for an older person, while 41,000 foreigners cared for a disabled person. These numbers contrast sharply with the above mentioned estimates of 650,000 to 1 million migrant care assistants. However, the validity of the survey-based estimates has to be doubted too. The estimates could be biased, for example, because frail elderly might be underrepresented in the survey[13], or because households might be hesitant to report their irregular domestic worker.

Table 3.5: Types of domestic workers hired by Italian households, 2003

Type of domestic worker	Percentage of households hiring	Foreigners as percentage of all hired	Estimated number of households hiring type of foreign domestic worker
Home help (*colf*)	6.2	32.3	450,986
Baby-sitter	0.9	18.4	39,064
Care assistant (*badante*) for older person	1.0	46.9	104,400
Care assistant (*badante*) for disabled person	0.4	46.7	41,246

Source: Indagine Multiscopo Sulle Famiglie 2003, own calculations, weighted data

Regardless of the great variation in quantitative estimates, it is clear that migrants have started to play an important role as domestic or care workers employed by families in Italy. Table 3.6 shows which types of households hire a (migrant) domestic worker. As can be seen, households consisting of people aged over 75 more often hire migrant workers. Table 3.6 also shows that of all elderly (aged over 75) living alone, 7 percent received paid domestic services from a foreigner, while only 2.6 percent hired a live-in domestic worker.

[12] It is literally asked whether people hire 'stranieri', i.e. foreigners. The definition of a foreigner is not elaborated any further, so we cannot be sure whether people mean foreign born or foreign national.
[13] The survey also contains a question asking whether the mother or father of the respondent is looked after by a migrant care assistant. This would apply to an estimated 347,517 Italians. Of course we have to take into consideration that parents might have more than one child, hence one elderly being cared for by a migrant care assistant could be reported by several respondents.

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Table 3.6: Percentage of households using private domestic services, by type of household, 2003

Age head of household	Type of household	Any domestic service	Any domestic service from foreigner	Foreigner living-in
Under 75	Single	7.3	2.3	0.1
	Couple	5.1	1.4	0.2
	Couple with child(ren)	6.7	1.9	0.1
	Single parent	7.0	2.0	0.1
75 or over	Single	17.8	7.0	2.6
	Couple	13.0	4.7	1.6
Total		7.8	2.5	0.4

Source: Indagine Multiscopo Sulle Famiglie 2003, own calculations, weighted data.
The head of household is the reference person.

The picture of private employment of migrant workers that emerged from the household survey largely corresponds with the one that came out of expert interviews. The most striking change that has taken place in recent years is the notable increase of migrants caring for older dependents. Migrant workers have not replaced Italian workers but have instead filled an almost new occupation. The number of immigrants working as baby-sitters and cleaners has also increased, but not as dramatically.

Migrant workers in agency-based care

With all the scholarly and media attention on migrant workers in private employment, there has been much less interest in the role of migrant workers in agency-based social care occupations. This is, not surprisingly, related to the fact that migrant workers play a much smaller role in agency-based social care occupations. In 2005 there were in total 6730 foreign nurses employed in health and social care. They formed 2 percent of the total workforce. Most of the migrant workers were employed in the private sector. A third of the migrant workers originated from the Central and Eastern European countries that entered the EU in 2004 (mainly from Poland) and another third from 2007 EU accession states (Romania and Bulgaria)(OECD 2008b: 12).

There is no evidence of immigrant workers playing a role of any importance in agency-based childcare services and no reason to assume that this is an important phenomenon. Since the agency-based employment of migrant workers in social care in Italy is so marginal and the data available extremely limited, the formal care sector will not play a central role in the rest of this chapter. A more extensive discussion of the role of migrant workers in agency-based care occupations follows in the next chapters on the UK and the Netherlands.

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To conclude, migrant workers have become very important as privately employed care assistants in Italy, as is summarised in table 3.7. This phenomenon is more important in elderly care than in childcare. There is a large group of formally employed private care assistants, and probably an equally large group of informally employed care assistants.

Table 3.7: Types of employment of migrant workers in social care in Italy

		Employer	
		Agency	**Household**
Employment relationship	**Formal**	*Some (not further studied)*	*Very large in elderly care, some in childcare*
	Informal	*Unknown (not further studied)*	*Very large in elderly care, some in childcare*

3.3 Explaining the reliance on private care workers

Why do families increasingly rely on migrant workers? In chapter 2, it was proposed that the employment of migrant workers could be related to employment conditions, to the organisation of the labour market, to the organisation of social care and the use of different types of services, and to immigration policies. While the importance of the labour market will be assessed in chapter 6, the other three factors are discussed hereafter. This section focuses entirely on private care.

Working conditions of Italian and foreign workers in private care.

The availability of survey data in which the employment of migrant and native domestic and care workers is distinguished makes it possible to compare the circumstances under which these workers are employed. Table 3.8 shows the average number of hours for which a family hires an Italian or foreign home help, baby-sitter or elderly carer. In all cases, Italians more often work between 1 and 20 hours a week, while foreigners work more hours. Most striking is the percentage of people living-in with the family they work for. Italian domestic workers hardly

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ever live with their employers, while 10 percent of all foreign home helps, 12 percent of foreign baby-sitters and 43 percent of elderly carers have a live-in arrangement.

Table 3.8: Average hours worked per week by Italian and foreign domestic workers, by type of work, percentages, 2003

Hours worked per week	Home help		Baby-sitter		Care-assistant for older person	
	Italian	Foreign	Italian	Foreign	Italian	Foreign
1-20 hours or varying	95	75	87	62	69	26
21-40 hours	4	12	12	16	13	24
> 40 hours	1	3	2	10	11	6
Live-in	1	10	0	12	7	43

Source: Indagine Multiscopo Sulle Famiglie 2003, own calculations, only heads of households, weighted data. Totals do not add up to 100 due to the rounding of numbers

The survey does not include information on the actual number of hours these live-in care workers work. However, other research has shown that live-in care workers often work very long hours. The survey of 1,000 migrant domestic workers carried out by Iref found that live-in carers worked on average 59 hours per week, compared to 39 hours for those living-out (Iref 2007: 31).

It can be concluded that migrant workers on average work longer hours than their native peers. They also live-in with their employer much more often. So far these findings confirm expectation A1 about unpleasant working conditions and a personal relationship with the employer. This expectation also pointed out that low pay could possibly contribute to the demand for migrant workers. The average wage earned by all migrant domestic workers in the Iref survey was €879 per month. Those who were irregularly present in Italy for less than 2 years worked on average (live-in and live-out combined) 49.9 hours per week for a monthly salary of €743. Those who had been in Italy for at least ten years and had obtained a regular status, on the contrary, worked on average 33.2 hours per week for a monthly salary of €1053 (Iref 2007: 36). Unfortunately there are no data available on the income of Italian domestic workers. For comparison, in 2007 a nurse auxiliary earned on average €1542 and a room attendant or chambermaid €1049 (ILO 2010). Although live-in domestic workers usually also receive board and lodging, the wages paid to migrant care workers in Italy are low especially compared to the more skilled nurse auxiliary. The wage earned by a migrant care worker is comparable to the wage earned by a chambermaid, but the latter is also the worst paid occupation of all 159 occupations reported by the ILO. Therefore, it can be concluded that migrant care workers receive a low pay.

In 2007, social partners concluded a collective agreement for domestic workers and care assistants (CCNL 2007). This collective agreement stipulates minimum salaries, dependent on the type of work carried out and on the vocational training and experience of the employee.

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These minimum salaries range from €550 per month for an inexperienced live-in domestic worker to €1050 for a trained care assistant. The collective agreement also limits the allowed maximum hours worked per week to 40 hours for live-out workers and to 54 for live-in workers. It prescribes some sick-leave payments, the right to maternity leave, and a notification period before dismissal. Although these employment conditions are inferior to those applicable in most other sectors, the fact that there is a collective agreement is rather exceptional in an international comparative perspective. Whether many employers comply with the collective agreement is another question.

A Familialistic care regime and the reliance on private migrant care workers

The Italian Familialistic care regime and the lack of public services are seen by many authors as the main explanation for the prevalence of migrant care workers:

> *In spite of increased efforts by local authorities [...] public provisions remained vastly inadequate in quantitative terms and not flexible enough to ease the reconciliation of work and family life.(Bettio et al. 2006: 278)*

Hereafter the impact of specific social policies and care regimes as a package is discussed separately for elderly care and childcare.

Elderly care

The Italian elderly care regime is strongly familialistic. As was discussed in section 3.1, many elderly people live together with one of their children or are cared for intensively by a relative, while public services for dependent elderly are scarce. Table 3.9 shows that on average people aged 65 or over more often rely on privately purchased services than on public services. While 9.5 percent received some kind of privately purchased domestic help, only 1.8 percent received any publicly provided service. Public and private services are predominantly provided to the very old and to those with chronic illnesses. Of the entire group of elderly aged 65 and over, only 9.5 percent receive some kind of privately purchased help; however, this increases to 31.6 percent for the group of chronically ill elderly aged 75 and over. Similarly, of all elderly aged over 65 only 0.9 percent lives-in with a full-time migrant care worker, but this percentage increases to 7.2 percent when we consider those aged over 75 with a chronic illness.

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Table 3.9: Use of private and public services by age group and presence or absence of chronic illness, 2003

Recipient's age	Percentage receiving privately purchased services: Any domestic help	Any domestic help from foreigner	Live-in migrant care worker	Percentage receiving public services
+65	9.5	3.4	0.9	1.8
+65 with chronic illness	26.2	11.9	5.7	5.9
+75	14.7	5.5	1.8	2.8
+75 with chronic illness	31.6	15.1	7.2	6.6
+85	22.2	11.0	4.6	4.4

Source: Indagine Multiscopo Sulle Famiglie 2003, own calculations, weighted data.

The data presented in table 3.9 suggest that the use of domestic services is related to the need for care. The data do not really clarify the relationship between private and public services. In fact, a closer look at the household survey data reveals that households that purchase private services rely on public services as often as those who do not buy private services. Moreover, table 3.10 shows that domestic workers are employed more often in the North and Centre of Italy, than in the South. As was shown earlier in this chapter (table 3.1), public services are also more commonly available in the North and Centre than in the South.

Table 3.10: Prevalence of Italian and foreign domestic workers in different geographic areas, 2006

	Number of domestic workers per 1000 citizens	
	Italian workers	Foreign workers
North	2.2	6.4
Centre	2.7	9.7
South + Islands	2.0	2.6

Source: INPS (2009) own calculations

These findings contradict the idea that there is a direct crowding-out effect between public investments in care services and private (migrant) care work (expectation A4). One possible explanation for the regional variation in the employment of migrant domestic workers could be related to the fact that table 3.10 only shows regularly employed domestic workers. It could be that migrant domestic workers in the South work irregularly more often. Another explanation for these finding could be that the general demand for non-familial elderly care services is larger in the Northern regions, where more women are working. Finally, the fact that public and

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private services are often used simultaneously also suggests that the publicly provided services are inadequate to cover the full care needs.

While publicly provided care services are insufficient, agency-based private care is expensive. The cost of a place in a residential care home is at least 1400 Euros per month (Mensini and Gambino 2006: 59). These costs can be (partly) covered by local authorities, but only when family resources have been exhausted. Buying private home care services on the regular market from a trained nurse would be even more expensive:

> *Hiring an Italian nurse 24 hours per day could cost 3000 Euros per month. Instead, with 800 Euros you can have a migrant at home (Interview, Caritas)*

The migrant care worker hence emerges as a cost-effective alternative for limited public services. An additional factor contributing to the attractiveness of this alternative is the attendance allowance (the Indennità di Accompagnamento, IA). As was discussed in section 3.1, around 10 percent of all Italian elderly receive such an allowance, because they are in need of long-term care. There is no control on how the IA is spent. The amount is too low to buy services on the formal market. However, with this cash benefit, combined with pensions or some family support, many dependent elderly can afford to hire a migrant care worker. That this attendance allowance is important was confirmed in a survey of its recipients carried out by Ranci and Pavolini. They found that 27 percent of all respondents – who all received an attendance allowance because of their dependence on continuous care – lived with a paid carer (Ranci and Pavolini 2008: 12).

In addition to these needs-based explanations for the employment of migrant care workers, there might also be a culturally embedded preference for a Familialistic form of care. The live-in private care worker may fit well with the ideal of family care. It is therefore questionable whether elderly or their family would opt for public services even if these were more widely available. To verify this idea, we can have a look at the results of a special Eurobarometer survey conducted in 2007, which asked several questions about preferences regarding long-term care. When asked about the way in which respondents would like to be looked after when in need of long-term care, the answers given by Italians do not differ substantially from the EU-15 average (see Appendix table A-4). Similar to all other Europeans, Italians dislike long-term care institutions, which are the preferred care option for only 8 percent of the Italians (compared to an EU-15 average of 9 percent). More than half of all Italians believe that 'institutions such as nursing homes offer insufficient standards of care', the same applies on average to 45 percent of Europeans. But hiring a personal care worker is not that much more popular (preferred by 16 percent of Italian respondents compared to 13 percent on average in the EU-15). Instead most Italians, like most Europeans, prefer to be looked after by a relative at home (44 percent for Italy and 39 percent for the EU-15). The great similarity

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between Italian preferences and the other Europeans and the limited preference for the personal care worker can both hardly explain why migrant care work has started to feature so prominently in recent years.

Italy differs from other European countries when it comes to the question regarding who should provide care services. Like other Europeans, Italians first of all point at the state, with 88 percent believing that the state should provide care services (compared to a European average of 95 percent, see Appendix table A-4). But unlike other Europeans, 68 percent of Italians believe that children should pay for care (40 percent for the EU-15 average) and 48 percent believe that care should be provided by relatives even if this would be at the cost of the relative's career (compared to 28 percent on average in the EU-15). These figures suggest that while Italy does not stand out when it comes to preferences for certain care services, it is exceptional in relation to what is expected from relatives. The choice for a migrant care worker could thus be related more to the moral (and legal) duty of children to arrange care for their elderly parents, than to the preference for this specific type of arrangement.

Of course the opinion data collected in one survey are not a strong empirical base. Nevertheless, it stands out that this survey does not support the idea that Italians would prefer a 'migrant in the family' model of care over other types of (public) services. This finding reinforces the crowding out expectation (A4). In addition, the findings of this section suggest that the Familialistic Italian care regime, which de-facto lays the responsibility for care provision primarily with family members, has contributed to the prevalence of private migrant care work. It were the families that sought an alternative solution for their heavy care burden.

Childcare

Table 3.11 shows the different care arrangements used by children according to the 2003 family survey (*Indagine Multiscopo Sulle Famiglie*). It shows that only 1.3 percent of 0 to 2 year old children and 1.7 percent of 3 to 5 year old children are cared for by a foreign babysitter. Why are migrant carers for young children relatively scarce, especially when compared to the large number of migrant workers employed as elderly carers? Contrary to the growing number of elderly, the number of children in the population is actually decreasing. As table 1.1 in the introduction showed, the Italian fertility rate is only 1.4 and among the lowest in the world. However, in the mean time more mothers are engaged in paid employment, which could in turn lead to more demand for care services.

From the age of three children can attend pre-schools (scuola maternal) almost full-time. Table 3.11 confirms that 84 percent of all children aged 3 till 5 attends a pre-school. Of

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the 0 to 2 year-olds, 15 percent attend a day care centre (asilo nido). This number is higher than the number of children attending public day care centres (see table 3.2), because the family survey data in table 3.11 include private day care centres. Slightly more than half of all day care consists of care in public day care centres, the other children attend private day care centre. The majority of children – 56 percent of 0 to 2 year-olds and 61 percent of those between 3 and 5 – are regularly cared for by a grandparent. Only 6 percent of all children are regularly cared for by a babysitter[14]. A further analysis of the survey data showed that only families in which both parents are working hired a nanny.

Table 3.11: Percentage of children using different types of care arrangements, by age of child[1]

	0-2 years old	3-5 years old
Day care	15.0	2.4
Pre-school	-	83.8
Babysitter	6.0	6.5
Foreign babysitter	1.3	1.7
Grandparent	56.3	60.6

Source: Indagine Multiscopo Sulle Famiglie 2003, own calculations, weighted data

[1] Because several types of care can be combined, the column totals can add up to more than 100. Parental care is excluded.

One factor contributing to the relatively small number of migrant workers employed as babysitters is probably the more extensive public provision of services, especially for the 3 to 5 year olds. In Italy, 'the care needs of elderly people are more strongly delegated to the family than those of small children' (Naldini and Saraceno 2008: 743). Hence, the simple crowding out effect of public services (expectation A4) provides a probable explanation. In addition, grandparents are apparently still willing and able to care for their grandchildren in large numbers. Whether this is a long-term solution, with older women increasingly engaged in paid employment, remains an open question. The possible explanations for the large differences in importance of migrant workers in child and elderly care will be further discussed in chapter 6.

[14] Of the children aged 0 to 2 who attend a daycare centre, 5.8 % are also cared for by a baby-sitter. Apparently the two types of childcare are not mutually exclusive.

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The impact of labour migration policies

Italian immigration policies for migrant care workers have been very expansive. Since 2005 work permit quotas have been issued regularly; regularisations were enacted in 2002 and 2009; and Romanians and Bulgarians are free to work as domestic workers and care assistants. This brings up the question whether immigrants are employed as care workers so often exactly because of these expansive immigration policies (expectation A7). This question can best be answered by looking at the timing of immigration policies and the political incentives for enacting expansive policies for care workers. These will be discussed extensively in the next section. Here it suffices to say that expansive immigration policies were enacted in response to the presence of migrant care workers. It was only after it became clear that many Italian families were hiring migrant care workers that the first regularisation of domestic and care workers was enacted in 2002. Also work permits have mostly been issued to migrant care workers already present in Italy.

It can be concluded that expansive immigration policies did not cause the employment of migrant care workers. More important is the fact that, in general, working irregularly in Italy is relatively easy. As a consequence, there is a large availability of irregular migrant workers willing to work as care assistants. However, this does not imply that expansive immigration policies have no impact. For they did allow many migrant care workers to obtain a residence permit and to be employed regularly.

It remains questionable whether the option of regularly employing a migrant care worker is attractive for Italian employers. As expectation A9 suggests, employers might actually prefer to employ more vulnerable undocumented immigrants. In the section on employment conditions above it was already discussed that regular migrant care workers are better paid and work fewer hours than irregular migrant workers. Not all families have been prepared to apply for the legalisation of their domestic workers. The newspaper *La Repubblica* cites an older woman who debated whether to regularise the migrant care assistant she employed:

> *I am worried I won't be able to afford it any longer. How much will it cost me? A lot, because with wages, deductions, holidays and the thirteenth month the annual costs surpass 14 thousand Euros*[15].

In the 2009 regularisation, families that wanted to regularize their domestic worker had to pay a 500 Euro fee. In addition they had to pay social security contributions retrospectively and risked having to pay back wages and holiday payments[16]. Estimates suggest that, when including all

[15] *La Repubblica,* 'Badanti in regola, famiglie in difficoltà', 03-09-2009
[16] *La Repubblica,* 'Badanti, la Cgil teme il boom di contenziosi', 25-08-2009

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the extra expenses, the regular wage costs are twice as high as the amount paid informally [17]. All this would make it financially unattractive to regularise a domestic worker.

Moreover, a regular domestic worker might also make a family more vulnerable. The newspaper *La Repubblica* tellingly titled an article: 'Care assistant regularised, family in trouble'[18]. A civil servant at the Ministry of Labour (Interview Ministry of Labour – 3) suggested that regular domestic workers would be 'more dangerous' for families, because they might sue their employers even when their employers have not done anything wrong. But it is easy to imagine that housekeepers and care assistants have good reasons to denounce their employers for not abiding by minimum wage laws or work time requirements. There are already various examples of lawsuits between families and domestic workers[19] .

There are enough reasons why a family could decide not to regularise their domestic worker. In the regularisation of September 2009, eventually 114,336 families applied for the regularisation of their care assistants and 180,408 families for the regularisation of their home help[20]. This number was substantially lower than expected[21]. Yet considering all the reasons why it might not be attractive to regularise a domestic worker, it is at the same time interesting to see that there were still so many families applying for a permit. Possibly, employers were motivated to regularise their care worker as a consequence of the more severe punishments for employing and housing undocumented immigrants that were introduced in the 2009 Security Package (see below).

In summary, this section on the explanations for the employment of migrant care workers found that migrant workers in general work longer hours and more often live-in with their employer when than their native peers. The large demand for private elderly care assistants is clearly related to the Familialistic Italian care regime with its limited availability of alternative services. The attendance allowance, available for everyone in need of long-term care, contributes to the fact that many Italian elderly or their families can afford to hire a migrant care worker. The large presence of irregular immigrants in Italy in general provides a source of cheap migrant workers willing to work long hours and to live-in. Chapter 6 will put these findings into a comparative perspective.

[17] *La Repubblica*, 'Badanti e colf straniere per ora poche domande per l' emersione', 11-09-2009
[18] *La Repubblica*, 'Badanti in regola, famiglie in difficoltà', 03-09-2009
[19] Interview with CGIL representative. See also *La Repubblica*, 'Badanti contro pensionati e litiga anche il sindacato', 10-04-2008
[20] Ministero dell'Interno, Dichiarazione di Emersione, Dati Devinitivi: 01-10-2009.
[21] *La Repubblica*, 'Badanti e colf straniere per ora poche domande per l' emersione', 11-09-2009

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3.4 Policy developments: embracing the 'migrant in the family' model of care

Direct policy responses to the employment of migrant care workers and indirectly related policy developments have both mostly sustained or even encouraged the development of a 'migrant in the family' model of care. Immigration policies have authorised the mass inflow and regularisation of migrant care workers. At the same time, public child and especially elderly care facilities have hardly been expanded. It appears that Italian governments have chosen to support the 'migrant in the family' model of care. This is particularly striking, given that centre-right and even anti-immigrant parties were often responsible for this choice. Below it will be examined how this could happen and whether supporting the migrant in the family model of care was an intentional choice.

In order to understand policy developments we have to understand the Italian political circumstances. For a long time Christian Democrats dominated Italy's multi-party system. Some unsettling political events in the early 1990s changed this situation. Judicial investigations known as the 'mani pulite' (clean hands) enquiry revealed widespread political corruption and resulted in the replacement of almost the entire political elite, including the disappearance (or renaming) of all important political parties. As a consequence, the dominance of political parties – especially of the Christian Democrats – decreased, giving more room for reforms induced by subsequent governments (Bull and Newell 2006: 11-12). At the same time, a broadly shared will to enter into the last stage of the Economic and Monetary Union (the introduction of the Euro) encouraged reforms that would help decrease Italy's vast budgetary deficits (Ferrera and Gualmini 2004; Natali 2004).

In 1996, for the first time ever, a centre-left coalition, led by Romano Prodi, took office. From May 1996 until June 2001 centre and left-wing political parties formed a majority in the Italian parliament. Due to an ongoing political instability, there were in fact four consecutive centre-left governments in this period (see table 3.12). Although the centre-left governments undertook several attempts to reform the Italian welfare state, its successes were limited by the instability of these governments. In 2001, Silvio Berlusconi came to power leading a centre-right coalition which included his own centre-right Forza Italia, the Alleanza Nazionale (the successors of the Movimento Sociale Italiano, a fascist party) and the Lega Nord (a populist party striving for the independence of northern Italy). One of the centre-right coalition's main aims was to combat irregular immigration. In 2006, Romani Prodi took over as prime-minister again, this time with a government consisting of eight political parties and depending on the parliamentary support of even more parties. After several votes of no-confidence, the government fell in 2008. Elections brought Berlusconi back into government. Due to a merger

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of his own Forza Italia and the Alleanza Nazionale into the Popolo della Libertà (PdL), Berlusconi became head of a relatively stable government consisting only of two parties: the Popolo della Libertà and the Lega Nord. This relative stability lasted until late 2010, when Fini decided to withdraw from the PdL.

Table 3.12: List of Italian governments, 1996 – 2009

Legislature	Government	Nr. of parties	Period	Political orientation	Parties
13th	Prodi I	4	1996-1998	Centre-left	Varying coalitions of l'Ulivo (group of centre-left parties), Christian Democrats, and Communists
	D'Alema I	7	1998-1999		
	D'Alema II	7	1999-2000		
	Amato II	8	2000-2001		
14th	Berlusconi II	4	2001-2005	Centre-right	Forza Italia (FI), Alleanza Nazionale (AN), Lega Nord (LN), Unione dei Democratici Cristiani (UDC)
	Berlusconi III	4	2005-2006		
15th	Prodi II	8	2006-2008	Centre-left	L'Ulivo and a variety of left-wing and Christian democratic parties
16th	Berlusconi IV	2	2008-?	Centre-right	Popolo della Libertà (PdL = former FI + AN), Lega Nord

Hereafter, the discussion of policy developments related to migrant care work is separated according to policy field. First the direct responses and indirectly related policy developments in immigration policy are discussed and explained. Second, policy developments in social care policy are examined.

Expansive immigration policy

Immigration policies targeted specifically at domestic and care workers have been very expansive. This started with the special provision for a regularisation of domestic and care workers included in the Bossi-Fini Act in 2002. Since 2005, quotas of work permits for the specific group of domestic and care workers have been assigned each year. In 2007 it was announced that Romanian and Bulgarian citizens became free to work in domestic and care services without any restrictions and in 2009 another specific regularisation was enacted. Meanwhile, controls on irregular immigrants have been tightened in the so-called 'Security Package'. Below, immigration policy developments and the politics behind them are discussed chronologically.

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Table 3.13: Italian immigration policies related to migrant care work

	Direct policy responses	Indirectly related policy developments
Encouraging	- Quotas - Regularisations (2002 & 2009) - Special permission for A2[1] nationals	- Opening of the labour market for all A8[2] nationals
Discouraging		- Security Package

[1] The two countries that joined the EU in 2007: Romania and Bulgaria
[2] The ten countries that joined the EU in 2004, minus Cyprus and Malta. A8 = Poland, Estonia, Latvia, Lithuania, Hungary, Czech Republic, Slovakia, Slovenia.

Towards the Bossi-Fini Act

In 1996, Prodi's new centre-left government committed itself to the introduction of a new comprehensive law to cover all aspects of both immigration and integration. The Minister of Social Affairs, Livia Turco (Democratici di Sinistra, DS), and the Minister of the Interior, Giorgio Napolitano (DS), were charged with the design of the new law. Besides the idea that previous laws had failed to effectively address the problems of clandestine immigration and the social integration of immigrants, Italy was under European pressure to improve its border controls. It had signed the Schengen Treaty which would soon come into force and which effectively made Italian borders European borders. Both government and opposition did not want to risk being excluded from Schengen (Zincone 2006: 357; Einaudi 2007: 210).

In a consultation process, academic experts and interest groups got the chance to voice their respective opinions (Einaudi 2007: 213). After that the bill became subject to political negotiations, during which the government was under continuous pressure from different sides. Since Schengen made a quick agreement necessary, the government had to convince the opposition not to filibuster the law. Meanwhile left-wing parties within the coalition opposed the more repressive proposals included in the draft bill. After a number of concessions to both sides the government managed eventually to convince all left-wing coalition parties to support a bill consisting of very strict measures and special detention centres for irregular immigrants, combined with yearly immigration quotas and supportive measures for immigrants already present. A regularisation of irregular residents was enacted only after the main law was established, in a 'Corrective Decree' (no. 380 of 16 October 1998). The regularisation was initially not intended, but under pressure from both Catholic and employers' organisations as

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well as from left-wing political parties, the government eventually had to yield to these demands (Zincone 2006: 358). As a result, around 220,000 undocumented migrants were regularised.

In the following years, migration was increasingly subject to negative public sentiments. In media coverage and public debates it became associated more and more with criminality (Sciortino and Colombo 2004: 109). In the run-up to the 2001 national elections, right wing political parties successfully made the perceived failings of migration legislation an issue in their political campaign. After the elections, a new migration law became one of the main priorities of the new centre-right government. Vice-premier Gianfranco Fini (Alleanza Nazionale) and Minister of Institutional Reforms, Umberto Bossi (Lega Nord), were charged with drafting the bill. Negotiations about the law were this time primarily a coalition partners' affair, and members of the opposition as well as societal groups were deliberately excluded. This contributed to a highly polarised and politicised atmosphere (Zincone 2006: 363-4).

At the time of the drafting of the Bossi-Fini Act, the Lega Nord and the Alleanza Nazionale represented the two most prominent anti-immigrant parties, advocating strict immigration control laws and opposing any regularisations. Berlusconi's own Forza Italia took a slightly less pronounced position (Geddes 2008: 354). From the outset coalition partner Unione dei Democratici Christiani (UDC)[22] voiced a more moderate position. The party was against too stringent measures and favoured a regularisation of undocumented workers (Einaudi 2007: 317). The UDC was supported by the same Catholic and employers' organisations that managed to push through a regularisation following the Turco-Napolitano Act.

In winter 2001-2002, the pressure on the government to include a regularisation increased. This pressure came from both within the government (UDC) and from civil society (Einaudi 2007: 319). Demonstrations took place in which older people, accompanied by their *badanti*, demanded the regularisation of these undocumented carers (Sarti 2004: 2)[23]. Soon after that, Roberto Maroni (Lega) announced that his party would endorse the regularisation of 'all these extra-communitarians, the majority of whom are women, who carry out activities of high social importance for families' (cited in Einaudi 2007: 317). A little later this was expanded to include all domestic and care workers. Once the intention to regularise domestic workers came out in the open, employers' organisations protested, maintaining that this would discriminate

[22] At the time there were in fact still two Christian Democratic parties: the Ccd and Cdu. Since the two parties merged into the UDC – Unione dei Democratici Cristiani – in December 2002, they will here be treated already as one party for reasons of simplicity.

[23] The demonstrations were organised by, among others, *Viva gli Anziani.* See numerous newspaper articles, e.g.:'Anziani in piazza per gli immigrati' in *Corriere della Sera,* 23/11/2001; 'Nonni e immigrati sono in piazza' in *La Nazione*, 18/01/2002, 'Immigrati come uscire dal caos' in *La Repubblica, 23/01/2002*. For further information see: http://www.santegidio.org/it/manifestazioni/20011122/index.htm

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against other migrant workers. In the end, the coalition gave in and a regularisation of all irregularly present migrant workers was enacted.

The Bossi-Fini Act further tightened the criteria for legal entrance and expanded the possibilities for the detention and expulsion of irregular immigrants. The yearly immigration quotas, set by the government, were maintained. While the regularisation of domestic and care workers was included in the Bossi-Fini Act, migrants working in other sectors, on the contrary, had to wait for a separate decree. The reason was that the name-givers of the Act (Bossi and Fini) did not want to be held personally responsible for the mass-regularisation of migrants (Einaudi 2007: 318). Notwithstanding whether they were personally responsible or not, the law paved the way for the largest regularisation in Italy's history, including the regularisation of 316,000 domestic and care workers.

Given Italy's history of recurrent immigrant regularisations, it is not really surprising that such a regularisation was enacted again in 2002. There is a widely shared belief that at a certain point:

> *There remains nothing else to be done than a special measure, a regularisation that at least for a period allows the regularisation of the position of these people. That's how it was done, but is has been done by the right, and it has been done by the left (Interview Caritas)*

Nevertheless, there had never been such openly anti-immigrant parties in a government enacting a regularisation. Moreover, the central role of domestic and care workers in this particular regularisation is striking. They were the only ones included in the initial law, while others had to wait for a separate decree. In the political process, the agreement on the regularisation of domestic and care workers paved the way for the regularisation of other undocumented immigrants.

Quotas and new EU citizens, 2003-2009

Italian immigration law foresees quotas for the entrance of new immigrants, which have to be set by the government on a yearly base. These quotas are set for nationals of countries with which Italy has reached special agreements ('selected nationalities') and for certain occupations. In 2005, Berlusconi's centre-right government announced a specific immigration quota for domestic and care workers for the first time. In that year, 15,000 domestic and care workers could enter the country, which was as much as the total set for other occupations (see table 3.14). In 2006 the same government allowed for the entrance of another 45,000 domestic and care workers, which was even more than the total (33,500) set for other occupations. When Prodi's centre-left government came to power in 2006, it announced an extension of the 2006

quotas. An additional quota of 350,000 work permits was made available for those who had already applied for such a permit following the normal 2006 procedure. This measure can be seen as a hidden regularisation.

Table 3.14: Quotas for non-seasonal immigration

	Selected nationalities	Domestic and care workers	Other occupations	Other	Total
2005	21,800	15,000	15,000	2,700	57,500
2006 – 1	38,000	45,000	33,500	3,500	120,000
2006 – 2		350,000			350,000
2007	47,100	65,000	45,900	12,000	170,000
2008	44,600	105,400	-	-	150,000

Sources: 2005 and 2006-1, (2007: 386); rest Presidente del Consiglio dei Ministri (2006; 2007; 2008)
Note: additional quotas were available for new EU member states in 2005 (79,500) and 2006 (170,000), after this, restrictions were lifted for A8 citizens. Normal restrictions still apply to A2 citizens, but not for domestic workers from A8 countries.

In the summer of 2006, Prodi's government removed the initial restrictions on labour migration from the Eastern and Central European countries that had entered the EU in 2004. When Romania and Bulgaria entered the EU in 2007, it was decided to keep access to the labour market restricted to certain occupations. Only domestic workers, agricultural workers, and employees in the tourism industry, the construction industry and the engineering industry could work in Italy without restrictions. The Minister of Social Solidarity, Paolo Ferrero, emphasised that, although the measure applied to a bigger group, in reality it would be most important for care assistants, many of whom were already present in Italy[24].

In 2007, the quotas for domestic and care workers were increased to 65,000. The government also intended to reform immigration legislation. Proposals for a new law included more flexible quotas for domestic and care workers, because, as Giuliano Amato, the Minister of Internal Affairs, stated, 'if for companies the number of migrant workers is foreseeable, it is not for family carers'[25]. However, negotiations over the new law progressed slowly and the centre-left government fell before any results were achieved.

Migration and its negative connotations were once again central to the 2008 electoral campaign of Italian right-wing parties. The alleged high crime rates among immigrants,

[24] *La Repubblica*, 'Allargamento Ue, porte aperte alle badante romene e bulgare', 01-01-2007
[25] Minister of the Interior Amato in 'Immigrazione, via libera alla riforma', *La Repubblica,* 24-04-2007

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especially Romani migrants, were an issue high on the public agenda[26]. The elections were won by a centre-right coalition, consisting of Berlusconi's Popolo della Libertà (PdL, a merger of the Forza Italia and the Alleanza Nazionale) and Bossi's Lega Nord. The new government immediately announced a series of repressive measures to combat irregular immigration and the criminality associated with it. Both Catholic associations and trade unions were strongly concerned with the position taken by the government. As a representative of the biggest trade union put it:

> *They want to make us believe that all the people's problems are attributable to this enemy number one which is immigration (Interview CGIL).*

The very stringent position on immigration of the centre-right government resulted in a moratorium of immigration quotas in 2008. The moratorium was motivated by the economic crisis that had just started. With so many people – Italian and foreign – becoming unemployed, it was argued that there was no need for additional immigrant workers. Exceptions were made only for some selected nationalities, and an exception was also made, once again, for domestic and care workers. For these, the quota even amounted to a new record: 105,400 domestic workers could enter the country (see table 3.14). Apparently it was believed that the economic crisis would have no impact on the need for housekeepers and care assistants.

In the mean time the government introduced a special 'Security Package' (Pacchetto Sicurezza), which, among other things, made being an irregular immigrant a criminal act. Moreover, a detention of 6 months to 3 years was set for people who rented out accommodation to irregular immigrants. When this package became law in July 2009, there were some worries about the effects it would have on migrant domestic workers. Catholic associations and interest groups such as Caritas and Acli (a Christian organisation for Italian workers), and prominent trade unions used these concerns as an argument to lobby for the regularisation of domestic workers irregularly employed in Italy.

Soon, the Minister of Family Affairs, Carlo Giovanardi (PdL), proposed a regularisation of migrant domestic workers. Initially this proposal led to strong disagreement within the government. Some government members, such as Minister of Employment, Maurizio Sacconi (PdL), supported Giovanardi's proposal. Others wanted to make a distinction between housekeepers and care assistants. They were of the opinion that only care assistants 'that were useful for the elderly and disabled people' deserved a regularisation, while for housekeepers 'there is no urgency'[27]. Lega Nord ministers were at first fiercely opposed to a regularisation.

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[26] See for example, *Il Giornale*, 'Otto italiani su 10: via i rom senza lavoro', 18-5-2008: 'more than Romanians, more than Albanians and North Africans, for Italians the Roma are the ethnicity [...] most dangerous for the public order'.

[27] La Russa in *La Repubblica*, 'Immigrati, Maroni contro La Russa "Non ci sarà nessuna sanatoria"', 7-7-2009.

Their main concern was that migrants not really employed as domestic workers would fraudulently use the regularisation to obtain a work permit. As minister Roberto Calderoli emphasised: 'I don't agree with the proposal for the regularisation of care assistants, many are false'[28]. In the end an agreement was reached and a 'selective regularisation' was to be introduced with the aim of distinguishing between fraudulent applications and those really working in Italy as domestic workers. The solution was found by excluding short-term foreign residents from applying for regularisation of their domestic worker. Moreover, employers had to earn a minimum income, thereby showing that they could really afford to hire a domestic worker.

Let us finally have a closer look at the actual use of quotas and regularisations. The numbers of applications for a domestic work permit have consistently been much higher than the quotas allow. Looking at 2007, for example, there were 371,709 applications for domestic work, compared to a quota of 65,000. Although officially a migrant worker has to apply for a work permit through the quota system before coming to Italy, it is well-known that most of these applicants are effectively already living and working in the country. The quotas should therefore be seen – and this is recognised by public officials – as an attempt to allow hidden regularisation – to allow families to regularise the domestic workers that are playing a relevant role for parents and children' (Interview Ministry of Labour – 3).

These hidden regularisations are not always successful. Of the 371,709 applications for a domestic work permit filed in December 2007, by February 2009 – 14 months later – only around 29,000 domestic workers had obtained and collected a work permit[29]. Many of the applications were deemed to be invalid, while many of those that were awarded were eventually not collected by the migrant in question[30]. The quotas therefore do not really resolve the large numbers of irregular migrants working in the sector and the government is aware of that. However:

> *They don't go and have a look, because they know that these [workers] cover an important part of family welfare. So there is this ambiguous attitude, that is: it's convenient to leave things as they are (Acli Colf).*

It seems therefore that the government is inclined to leave the situation as it is, officially allowing migrant care workers to enter the country and at the same time tolerating those who are working irregularly. This attitude is ambiguous, given that official government policy takes a very strong position against irregular immigrants.

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[28] *La Repubblica* 'Badanti, si allarga il fronte pro-sanatoria', 7-7-2009.
[29] Based on data provided by the Ministry of Labour in April 2009.
[30] The reason for not picking up granted work permits is that migrant workers who are already irregularly working in Italy have to return to their country of origin where they have to collect their permit at the Italian consulate.

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Explaining the special position of domestic and care workers in Italian immigration policies

Domestic and care workers have increasingly taken up a special position within Italian immigration policy. Already in 2002 an initial regularisation programme was targeted at this specific group. After the accession of Romania and Bulgaria to the EU, citizens of these countries were not allowed to work in Italy, but an exception was made for domestic and care workers. While in 2008 entering Italy was made more difficult for most migrant workers, domestic and care workers were ascribed a higher quota than ever before. How can we explain this special position of migrant care workers?

As was expected (expectation C2) centre-right governments were, in general, stricter on immigration, while centre-left governments took a more positive stance towards immigrants. The Bossi-Fini Act, enacted by a centre-right government, was more restrictive than its predecessor: the Turco-Napolitano Act enacted by a centre-left government. It was again a centre-right government that enacted the Security Package with its measures against irregular immigrants. These developments are also in line with the expectation (C3) that populist or radical right parties induce more restrictive policies, since the Lega Nord played an important role in the design of these restrictive policies. However, the expansionary immigration policies for the specific category of care workers have been enacted both by centre-right and by centre-left governments. Even the right-wing governments that included the Lega Nord have persistently made exceptions for domestic and care workers. This fact contradicts expectation D1, which proposed that the presence of extreme right parties would bring the government to favour restrictive immigration policies above everything else. That even the anti-immigrant Lega Nord was responsible for expansive policies for migrant care workers is possibly related to the fact that this party relied on an electorate consisting of North-Italian middle class families, many of whom hire a migrant care worker[31].

Expectation C1 suggested that trade unions take an ambivalent position on immigration. It is therefore striking to see that trade unions lobbied actively for a more expansive immigration policy for migrant care workers. According to Freeman (see chapter 2 and expectation C1) the position of trade unions depends on whether migrant workers replace or supplement native workers. In this chapter it was found that migrant care workers do not replace native workers, on the contrary. Migrant care workers work in an occupation that previously hardly existed. Following Freeman, it becomes tempting to ascribe the positive stance of trade unions to the fact that migrant care workers are supplemental. However, in Italy civil society groups such as trade unions, employers' and Catholic organisations have generally displayed

[31] As was pointed out to me by Giovanna Zincone.

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positive attitudes towards migrant workers (Einaudi 2007). The positive position of trade unions is not unique for migrant care workers, but applies to all immigrants.

The extent to which civil society groups could influence policy making depended strongly on the coalition in government. While the centre-left continuously sought advice from non-governmental organisations, the centre-right chose its own course. Trade unions were deliberately excluded from any consultation, while other organisations such as the Catholic Caritas were only invited when their services could be of use for the government. It can be concluded that while civil society has been an influential adviser to the centre-left governments that usually already agreed with them, they have had little voice when the centre-right was in power. Continuity in the approach towards migrant care workers can therefore hardly be ascribed to these interest organisations.

According to expectation C4, policies enacted without much publicity, or by bureaucratic or technocratic bodies would be more positive towards immigration or immigrants. Strikingly, in Italy, none of the expansive policies for migrant care workers were enacted secretly, away from the public eye. On the contrary, policies were always announced very openly in the media. It has to be concluded that there is not a lot of disagreement on the issue of migrant care workers. As was noted by a representative of Caritas:

> *This is a fairly peaceful area, in which we all find common interests. There are no very different views, also not between government and organisations. [...] So all together it's not a very conflictual sector, fortunately (Interview Caritas).*

It is a widely shared belief that migrant workers provide a service that is fundamental for Italian families. A representative of Acli Colf, a Catholic organisation representing the interests of domestic workers, explained the position of Berlusconi's right-wing government:

> *This government – as you know – is certainly not favourable towards immigration, on the contrary. However, there is a problem. That is, the role of the family. And families have an absolute need for these workers (Interview Acli Colf).*

Apparently, families' needs are a strong legitimisation for devising expansive immigration policies. These needs even overrule strong anti-immigrant sentiments or labour market considerations.

There is one more factor that contributes to the fact that policies for migrant care workers are seemingly sheltered from anti-immigrant sentiments. In Italy, such negative sentiments often concern security and the perceived criminality of immigrants (Sciortino and Colombo 2004). Since most care and domestic workers are female and Catholic – and in media coverage and public debates they are usually described as hard working faithful women – they are not considered to be such a threat to society:

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> *It is the category of workers that probably gives the fewest problems in Italy (Interview Caritas).*

The fact that migrant care work is mostly done by women and is entirely confined to the private sphere also has led to little discussion about ensuring proper employment conditions for workers. In the quote below, for example, the situation of women denouncing abuse and harassment is described as 'a bit ugly' ('un po' brutta'), while the problem is taken much more seriously in the agriculture industry. However, the last sentence of the quote could also literally have applied to female care workers:

> *Many cases are recorded of women who denounce abuse, harassment, etcetera. This is something a bit ugly. [...] But in agriculture for example, these are much more widespread phenomena [...] because they do not have any right, they work irregularly, they have no kind of protection and are subject to very long working hours (Interview Caritas).*

In conclusion, the argument that families need migrant care workers has played an important role in Italian immigration policy making. It is often voiced in the media, it is brought forward by interest organisations, and it is also a belief shared by politicians from both the left and the right. The argument has overruled anti-immigrant sentiments, helped by the fact that these female, often Catholic migrants were rarely seen as a societal threat. Families' needs also took precedence over the need for regular work and decent employment conditions.

Social policies

Direct policy responses to migrant care work have been less outspoken in social policy than in immigration policy. There have been some regional initiatives encouraging the regular employment of migrant care workers. Apart from that, there are no social care policies that explicitly encourage migrant care work. On the contrary, indirectly related policy developments – or the lack of these - have sustained migrant care work. There has been no reform of the social care system, meaning that public care provision continues to be scarce. Spending of the widely available attendance allowance continues to be completely unregulated. Only the presence of a public pre-school system could be seen as indirectly discouraging the employment of migrant nannies. Policy developments in social care and the politics behind them will hereafter be discussed in chronological order.

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Table 3.15: Italian social care policies related to migrant care work

	Direct policy responses	Indirectly related policy developments
Encouraging	- Tax deduction of expenditure on family assistants - Regional initiatives supporting regular employment of migrant care workers	- Uncontrolled attendance allowance - No reform of the social care system
Discouraging		- Public pre-school system

In 1997, the centre-left government, led by Romano Prodi, set up a commission ('Commissione Onofri') to evaluate Italian social policies and propose options for improvement. The explicit task of the commission was to propose a set of reforms that would not increase the overall spending on social policies. Instead, expenses on social insurance schemes had to be reduced, thereby making funds available for the lesser funded risks or non-insured risks, such as poverty and old age dependency. One of the Commission's proposals was to create a comprehensive scheme of support for the elderly in need of long-term care. All dependent elderly people should have the right to receive a standard package of services, which would be coordinated through a *Fondo per i non autosufficienti* (a fund for the non self-sufficient). The fund had to be financed through a new targeted tax in combination with some spending cuts in public pensions (Gori 2006: 29). Family policies and childcare were mostly absent from the Commission's proposals (Saraceno 2007: 245).

The amount of attention devoted to the issue of childcare slowly increased in the second half of the 1990s. Concerns about decreasing fertility rates and low female employment rates placed the issue on the political agenda. However, according to Saraceno this attention has been mostly symbolic (Saraceno 2007: 250). Nevertheless, in 1999 a bill was passed that at least addressed the childcare system. Although it did little to decrease regional differences, it did emphasise the importance of childcare for the education and socialisation of children as well as for the access to the labour market of women. Therefore, the bill introduced standards of qualifications for childcare providers. It also prescribed a maximum parental fee. Local communities could ask parents to pay for a maximum of 30 percent of the actual childcare costs (Bimbi and Della Sala 2001: 143-4).

In 2000 the 'Framework law for the realisation of an integrated system of social interventions and services' (Legge quadro 2000/238) was enacted following on from the Commission Onofri's recommendations. Although it contained a number of intentions for the

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improvement of social service provision for the frail elderly, most suggestions of the Commission Onofri remained unrealised. Most importantly, no reform was envisaged of the financing of care services. The proposals of the Commission Onofri turned out to be the only moment during the centre-left legislation (1996-2001) at which significant attention was paid to the issue of long-term care for the elderly (Gori 2006: 29-30).

In a constitutional reform that was approved just before the end of the centre-left government in 2001, the responsibility for the provision and regulation of social services was exclusively entrusted to the regions. This devolution of power partly offset the little progress that had been made in the fields of child and elderly care, making national intervention even more complicated (Gualdani 2004: 45). In general, a fundamental problem for the expansion of both child and elderly care services at the community level remained the lack of funding.

Berlusconi's centre-right government, which took over in 2001, introduced some initiatives to promote childcare services by companies. These measures, however, were later found unconstitutional because of the 2001 constitutional reform. They were a form of unacceptable national interference with regional competences (Saraceno 2007: 251). National government can only intervene by setting 'essential levels of assistance' ('Livelli Essenziali di Assistenza') for local communities, in which they can set requirements for the minimal services that have to be provided by local communities. But national governments cannot decide how these services should be provided (Saraceno 2007: 252).

Berlusconi's government did initially pay some attention to the issue of elderly care. This attention derived primarily from the Minister of Health, Girolamo Sirchia, who repeatedly underlined the insufficiency of the long-term care system in Italy. However, he failed to present any comprehensive plans and gave up on the issue in 2003, when it became clear that the coalition was not prepared to endorse any reform plan (Gori 2006: 30-1). In the same year, the parliamentary Social Affairs Committee presented another proposal for a unified law on long-term care, including again a national fund for dependent persons (*Fondo nazionale per il sostegno delle persone non autosufficienti)*. The proposal included the investment of 4.5 billion Euros annually, raised through extra taxations. It was broadly supported by parliamentarians from both the governing parties and the opposition, but it was blocked by the government, which was unwilling to increase fiscal pressure in any way. Even a revised plan that required less tax revenues was stopped (Gori 2006: 31-2).

In 2005, three pensioners' trade unions[32] – supported by many other organisations – submitted a proposal for a new law on provisions for dependent people ('non-autosufficienza').

[32] The big Italian trade union confederations each have their own pensioners unions: the CPI CIGL; the UILP UIL; and the FLP CISL.

For this 'bill of popular initiative' ('legge di iniziativa popolare') they had gathered more than half a million signatures. In January 2006 the bill was sent to parliament, but it was immediately torpedoed by the centre-right parties.

Berlusconi's government did introduce a bonus for families that regularly hired a migrant to care for a dependent family member in 2005. Part of the expenditures on these 'family assistants' were made tax-deductible (Bosi 2005: 106). The explicit goal of the measure was to make it more attractive for families to declare their care worker and pay social security contributions for her or him. Some regions (e.g. Tuscany) have taken similar initiatives. They provide care budgets to assist families to buy the services they need on the market, on the condition that they regularly employ their (migrant) care worker.

When Prodi took over again with a centre-left government in 2006, there was an agreement within the government on the need for a more comprehensive long-term care system as well as on the need to expand childcare services. The government committed itself to finally establish a national fund for long-term care. Under the leadership of Minister Ferrero of Social Solidarity the cabinet did indeed create such a fund. The fund consisted of additional spending on long-term care of 100 million Euros in 2007 (Ministro della Solidarietà Sociale 2007). Later, under Berlusconi's centre-right government, the funding was expanded to 300 million in 2008 and 400 million in 2009 and 2010 (Ministro del Lavoro 2008; 2010). However, in the organisational structure nothing changed, meaning that local communities continued to have complete discretion over how the funds were spent. There were attempts to set national standards for 'essential levels of assistance' for dependent people, but an agreement was not reached before the government fell in 2008. Some regions used the extra funds to provide more services, some decided to provide extra financial transfers, others used them to organise training for migrant care workers, and others again did nothing at all.

Prodi's government also made extra funding available for the expansion of childcare services. An 'Extraordinary plan for the development of socio-educational services for young children'[33] set aside an extra 446 million Euros of national grants for the expansion of childcare services. The government also set targets for coverage rates. According to the target, an average of 13 percent of children between 0 and 2 years should be in public or publicly funded day care centres, with a minimum coverage rate of 6 percent in every region. These targets were to become part of the 'minimum levels of assistance' but as for elderly care, an agreement was not reached in time. In January 2008 Prodi's government fell as a consequence of enduring internal conflict between the eight coalition partners.

[33] Piano straordinario per lo sviluppo dei servizi socio-educativi per la prima infanzia, http://www.politichefamiglia.it/documentazione/dossier/piano-straordinario-per-lo-sviluppo-dei-servizi-socio-educativi-per-la-prima-infanzia.aspx.

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Berlusconi's new government set out its plans for welfare state reforms in a green paper and a white paper both titled 'La vita buona nella società attiva' ('The good life in an active society'), in which it emphasised the importance of the third sector and private welfare provision and the subsidiary role of the state. Regarding childcare, a plurality of solutions, ranging from workplace childcare to 'inter-family services' should be encouraged (Ministero del Lavoro 2008: 15). As for the elderly, the green paper emphasised that the family is the main locus where they find solutions 'for their needs and their fears', while they can at the same time contribute to the family by taking care of young children. 'It is this intergenerational pact that we want to promote' (Ministero del Lavoro 2009: 34).

Not mentioned in the whole discussion above was the attendance allowance (Indennità di Accompagnamento). In the debates surrounding elderly care, it has been suggested several times to integrate this attendance allowance with other care services, creating a more complete elderly care system. However, such attempts have always been unsuccessful (Da Roit et al. 2007: 661). The Indennità is seen as the backbone of the Italian elderly care system and as such it should not be touched (Interview Ministry of Labour – 2).

To be mentioned, finally, is the collective agreement for domestic and care workers which was concluded in 2007. The collective agreement includes several rights, such as paid sick-leave, maternity leave, and a notification period before dismissal. However, these rights are still inferior to the employment conditions in most other sectors. The trade unions take a pragmatic position on the issue. If the employment conditions were to improve further, they argue, this would discourage families from regularising their domestic workers (Interview UIL-TUCS, UIL).

Explaining limited change

The discussion of social policy developments described above shows that, in line with expectation B2, centre-left governments have been in favour of the expansion of social services for both the elderly and children, while centre-right governments have remained mostly passive on these issues. Nevertheless, the initiatives taken by centre-left governments have not been very effective. Developments in social care in Italy have been marked by the country's fragmentary political system. The centre-left governments turned out to be unstable, with an average tenure of less than 1.5 years. The sharp ideological differences between the consecutive centre-right and centre-left governments ensured that policy initiatives introduced by one government were not carried on by the next. Italian developments are characterised by an inertia

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of the kind predicted in expectation B4. Left-wing governments have not been able to change the institutional legacy of limited public involvement in the provision of social care services.

Another institutional factor which contributes to the lack of reform is the decentralised nature of social assistance and care provision. Because of the far-reaching decentralisation of responsibilities for service provision contained in the constitutional reform of 2001, the options for national governments have been limited. They can increase funding, as Prodi's government did in 2007, but they cannot decide how local communities have to spend this funding. Alternatively, the national government can set minimum levels of assistance (LEAs), but so far it has not managed to do so.

Regardless of the institutional fragmentation, it remains remarkable that elderly care has not received more attention in political debates. The country's population is ageing at one of the highest rate of the entire European continent (see table 1.1), while its public services for the elderly are among the least generous. The increasing need for care services that results from population ageing, could have urged the Italian government to expand public provision (expectation B1). It seems, however, that the situation never became that pressing for the Italian government:

> *This theme has been totally obscured by the government. Because it is difficult to broach […] There is great awareness among the people, but it isn't expressed in public opinion. It doesn't reach the newspapers, it doesn't reach the media (Interview SPI CGIL).*

That this theme is so obscured is surprising in a society in which the elderly are even represented by their own pensioners' trade unions. Apparently, there is no feeling of emergency. Local governments have not been overloaded by demands for long-term care services and families are relatively satisfied by the way the system presently works. This lack of pressure is related to the presence of migrant care workers who 'have furnished a response to a need, which in the past years has increased strongly' (Interview Ministry of Labour – 2). It seems that the cheap and convenient migrant care workers 'saved' the Italian Familialistic elderly care regime. It averted urgent pressure, thereby allowing the Italian state to continue along the same road. Whether the elderly care system would have been reformed in the absence of migrant care workers is impossible to know, but it would at least have led to a greater sense of urgency concerning the situation of the Italian elderly.

Some scholars have suggested that the availability of migrant carers would even crowd out other care services (Bosi 2005; Lamura 2008). The presence of convenient and cheap migrant workers would have led to a decrease in the use (and hence availability) of residential and home care services. In an interview at the Ministry of Labour (2) this idea was confirmed. However, when looking at the actual development of publicly funded care services, there is no

evidence of decreasing availability. For example, while in 2003 1.6 percent of all Italians aged over 65 spent some time in a nursing home (Ministero della Salute 2004), this percentage had increased to 1.9 in 2007 (Ministero della Salute 2009). It should be noted that these figures refer only to nursing homes, which provide many medical services. Unfortunately, data on the development of privately funded residential care facilities are not available.

Finally, coordination between elderly care policy and immigration policy seems to be limited. As a civil servant at the Ministry of Labour admitted: 'I have to say, we have never worked together directly on these issues' and 'our colleagues at Immigration don't ask us for that kind of information' (Interview Ministry of Labour – 2). Although there might be some coordination at government level, we can hardly speak about a comprehensive strategy. Instead, the fact that both social care and migration policies endorse migrant care work is only a conjuncture of policy developments in two separate fields.

3.5 Conclusion

The quote cited at the beginning of this chapter neatly summarises how central migrant care workers have become in the Italian society. Not only are they an important source of care provision for the Italian elderly, but on top of that, they have been embraced by Italian policy makers as a phenomenon that should be 'encouraged and nourished', because it provides a 'flexible service, more adapted to the needs of families, controlled and run directly by relatives' (Ministero del Lavoro 2009: 33).

This chapter has shown that in Italy migrants are very often employed as private care assistants, mostly to care for an older dependent family member. Less numerous are the migrants employed as nannies. It was found that migrant care assistants work long hours, for low pay. They often live with their employer. The great growth in the employment of migrant care assistants is related to a lack of public provision of care services, to generous cash benefits, and to the large presence of irregular migrants in the country. The migrant care assistant provided a convenient solution for families in need of support.

Direct policy responses and indirectly related policy developments have mostly sustained the 'migrant in the family' model of care, but this migrant care model was certainly not designed by the Italian government. On the contrary, it has developed completely from below, following initiatives taken by families. Policies have only responded later, yet with the continuing lack of public services, the attendance allowance, the additional tax-breaks and cash-benefits for families regularly hiring a personal carer, and the immigration quotas specifically targeted at care workers, there can be no doubt that Italian policies have sustained migrant care

work. The legacy of a Familialistic care regime can explain many of these policy developments. The heavy reliance of families – so central in the Italian welfare regime – on migrant care workers convinced policy makers that expansive immigration policies were needed. At the same time, the presence of cheap and convenient migrant care workers absolved the Italian state from reforming its care system.

The strong reliance on migrant care workers endorsed by public policies has brought some scholars to worry about the future of long-term care in Italy:

> *[T]he short-term efficiency of the 'foreign minder' model may in fact be at the cost of its long-term sustainability, insofar as short-term benefits may jeopardize (or pre-empt the search for) more viable long-term solutions (Bettio et al. 2006: 283).*

This chapter has not found evidence of an actual decrease of public service provision, but findings confirm the idea that migrant care workers have relieved pressure on the government to reform the public long-term care system. Another factor that should raise doubt about the long-term sustainability of the model is the fact that migrant care workers are attractive because they are willing to work long hours for low pay. When migrants become regularised, or when they have resided in Italy for a long time, they start to earn higher wages and to work fewer hours a week, making them unaffordable for many Italian families. Therefore, to sustain the Italian model of migrant care work, a continuous inflow of vulnerable migrants willing to work under bad circumstances would be necessary.

The explanations for the importance of migrant care workers and the policy responses to the phenomenon will be assessed in a comparative perspective in chapter 6 and 7. First, however, the thesis will focus on the two other case study chapters, starting with the United Kingdom.

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4 THE UNITED KINGDOM: A RELUCTANT RELIANCE ON MIGRANT CARE WORK

In the United Kingdom, migrant workers in social care are mostly employed in agency-based elderly care. The number of migrants formally employed as care assistants or home carers has risen in the past years. In the childcare sector, on the contrary, migrant workers rarely work in day care centres or nurseries. Instead, they are more often privately employed as nannies or childminders. In both childcare and elderly care, the market for care services is more developed in the UK than in Italy or the Netherlands. Migrant workers seem to have become an important element of this market. This chapter explores why a demand for migrant workers emerged in formal agency-based elderly care, but not in private family-based elderly care, and in private family-based childcare, but not in nurseries and other day care centres.

Direct policy responses to migrant care work have been mostly discouraging. In 2007, the Home Office tightened eligibility criteria for work permits for 'senior care assistants'. In response, a large lobby for a more liberal work permit policy emerged, in which trade unions and employers cooperated. The lobby has not been very successful, since work permit criteria for senior care workers in the new points-based immigration system are even tighter. Meanwhile, consecutive governments have debated whether to reform the social care sector, but so far without many results. More effective has been the continuous expansion of public investments in childcare services.

In recent years, there has been some research on the employment of migrant workers in the social care workforce (Moriarty et al. 2008; Hussein et al. 2010). Especially relevant is the research by the Oxford research centre COMPAS. It includes a large survey of elderly care providers as well as interviews with migrant care workers (Cangiano et al. 2009). This chapter will frequently rely on the findings of this study. Regarding the private employment of migrant workers, there is the earlier discussed work by Williams and Gavanas (Williams and Gavanas 2008). In addition, there has been some work done on the importance of migrant domestic workers (Anderson 2006; Cox 2006) and their role as private carers for the elderly (Gordolan and Lalani 2009). In general, however, data on the private employment of migrant workers is scarce. Finally, as in Italy, there is no research explicitly assessing the policy responses to migrant care work.

Before going into the British case study it has to be remarked that social care policies for the elderly in the UK are decentralised, meaning that Wales, Scotland, Northern Ireland and England each have their own social care policies. This chapter will focus on England, for two reasons. First, England is by far the largest of these four regions, making up around 84 percent

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of the population in the United Kingdom. Second, the English region is the only one in the UK that does not have its own government. Instead the region is governed by the central government. Policy makers operating at the same governmental level could therefore be interviewed about immigration policies (national) and social care policies (regional). One other thing that should be noted is the English distinction between social care and long-term care. While social care refers to assistance with daily living, long-term care comes closer to health care, targeting people with chronic illnesses. In this chapter, this distinction is not followed. As in the rest of this thesis, long-term care refers to the subset of social care that is targeted at dependent adults.

Empirically, this chapter relies on an analysis of the UK Labour Force Survey 2008-4th quarter, on 9 interviews with a total of 13 policy makers and interest group representatives, on policy documents, newspaper articles, and on secondary sources[34]. Hereafter, the first section will start by describing the context of the British welfare state, the organisation of its child and elderly care systems and a short history of immigration. Section 4.2 then presents the available data on the employment of migrant care workers, followed by a section discussing the explanations for the demand for migrant workers. Section 4.4, finally, assesses direct policy responses to the employment of migrant care workers and the indirectly related policy developments in social and immigration policy.

4.1 Care and migration in the United Kingdom

The British welfare state and employment

The United Kingdom is often depicted as a Liberal welfare regime (Esping-Andersen 1990). Indeed, the British welfare regime has many means-tested social assistance based programmes, as is one of the characteristics of a Liberal welfare regime. These programmes are, however, often more than rudimentary, providing substantial income replacement and services for the less well-off. The foundations of the British welfare state were laid by William Beveridge right after the end of World War II. He proposed to introduce a social insurance system to provide a minimum income for all households, as well as National Health Service (NHS). Beveridge's ideal consisted of a typical male breadwinner model, in which women were to stay at home and provide informal care services. This model was strongly entrenched in the British welfare state as it was developed in the post-war decades (Lewis 1992).By the 1970s the British welfare state

[34] This chapter has greatly benefited from my stay at COMPAS in Oxford as a visiting researcher in autumn 2008.

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had developed into 'a midsize welfare state with modest income transfer programs and relative extensive and interventionist policies in health care and housing' (Pierson 1996: 161-2).

Under Thatcher's Conservative government the British welfare state was downsized. Although the NHS and social assistance programmes remained in place, housing and pension policies were substantially retrenched (ibid.: 163). Thatcher's government also tried to eliminate labour market rigidities by lowering unemployment benefits and abolishing employment protection regulations (Lloyd et al. 2008: 28). One central element in Thatcher's policy was to reduce public sector employment in order to achieve budgetary restraint. Many public services were transferred to the private service sector, which was much less unionised. This politically weakened public sector trade unions (ibid.). The results of nineteen years of Conservative governments (from 1979 until 1997) were a strong increase in wage inequality and a growing incidence of low-paid employment (Iversen and Wren 1998: 536; Lloyd et al. 2008: 15).

Fighting poverty became a priority of the Labour Party that came to power in 1997. One of the measures taken was the introduction of a minimum wage in 1999, which at the time was £3.60 per hour (Metcalf 2008) and, by 2010, had increased to £5.80[35]. Employment rates increased in the 1990s, especially among women. A large share (38 percent in 2008, see table 1.2) of these women work part-time (Lloyd et al. 2008: 21). In comparison with other European countries, Britain is still characterised by high income inequality and high poverty rates. Regardless of Labour's efforts, the percentage of low-wage workers has hardly declined. Lloyd et al. conclude:

> *Britain now tends to resemble the United States rather than continental Europe in providing economic incentives for individuals to take up paid work at the bottom end of the labor market (Lloyd et al. 2008: 22).*

When Beveridge laid the foundations of the British welfare state, both child and elderly care did not feature prominently in his plans. Since Beveridge envisioned a male breadwinner model, public childcare services were poorly developed. On the other hand, although social care services were intentionally kept out of the NHS, these care services expanded substantially in the post war decades. Below, developments in child and elderly care will be explored in more detail.

Elderly care

Until the Second World War, old age dependency was addressed in poor laws. Their core principle was that the responsibility to care and pay for care fell upon family members. Poor houses existed for those who could not rely on any family or financial support. The better-off

[35] http://www.direct.gov.uk/en/employment/employees/pay/dg_10027201

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who had sufficient financial means often used domestic servants as a source of care (Means and Smith 1998; Baldock 2003: 124). When the National Health Service was established in 1948, following Beveridge's recommendations, care services for older people were excluded and delegated to local authorities (Baldock 2003: 126). The 1948 National Assistance Act described the responsibilities of local authorities: 'to provide residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them' (Wanless 2006: 11). While the National Health Service was to be national and free of charge, social care services could carry charges and were means tested, meaning that they were more residual.

Initially, it was believed that the best way to combat old age dependency was to improve institutional care (Baldock 2003: 128). Therefore, the financing of local authority provision was almost entirely focused on residential care, while support for people in their own homes was left to voluntary organisations (Means and Smith 1998; Baldock 2003: 129). There was a clear class difference. While the well-off paid for a good home or private help, older people with no other income had to rely on local authority old people's homes (Baldock 2003: 129). While institutional care expanded, it was suggested already in the 1950s that elderly people should have more opportunities to stay at home (Wanless 2006: 11). Gradually, domiciliary services were developed, consisting of nursing services provided and financed through the NHS as well as home help and day care centres which were largely organised by voluntary organisations and financed by local authorities (Baldock 2003: 130). Meanwhile, in the 1980s social security benefits were increasingly used to pay for private residential care homes (OECD 1996: 179). As a consequence, the number of elderly people using residential care provisions increased by 57 percent between 1980 and 1991 (Land and Lewis 1998: 55) and the costs of residential care within the social security system increased from only a couple of million in 1979 to 900 million in 1988.

In the 1980s, Thatcher's administrations explicitly aimed to increase the provision of care services provided by the independent private and voluntary sector, while public provision had to be limited (Land and Lewis 1998: 55). The use of social security benefits for residential care was considered a great problem. However, the government 'was anxious not to inflict damage on the private providers of institutional care' (ibid.: 55). Therefore, it was decided to transfer the financial resources entirely to local governments, who became responsible for all social care services (Land and Lewis 1998: 55). The 1990 NHS and Community Care Act encouraged the contracting out of most public provisions to voluntary and for-profit providers. The development of a market in social care was part of a series of 'Thatcherite' policies seeking to reform public sector bureaucracy and to introduce market principles (Wanless 2006: 15).

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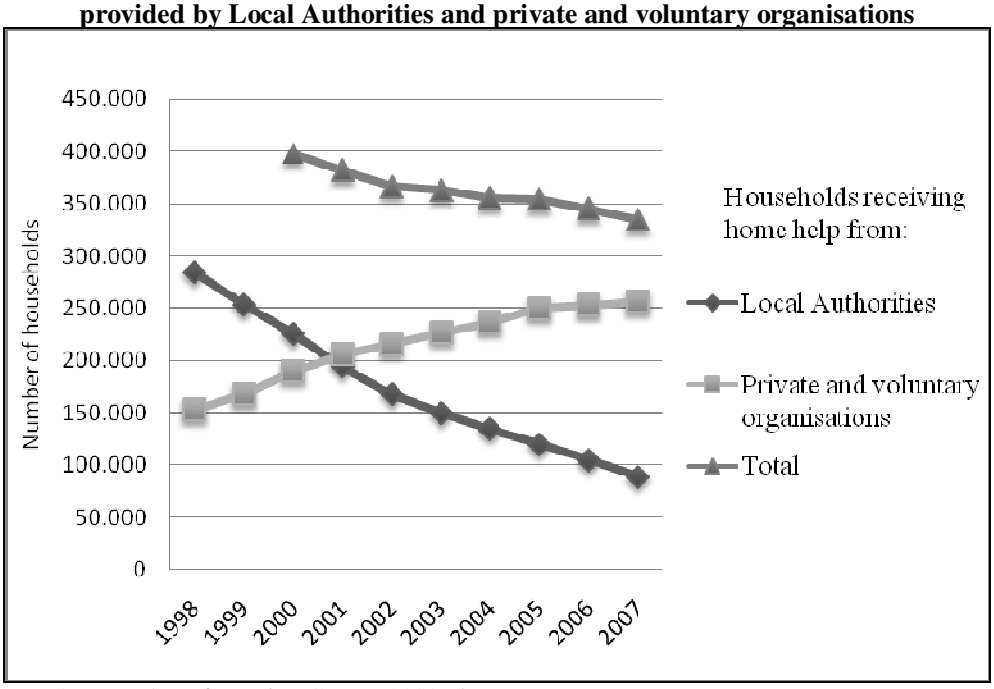
The trends started under Thatcher were not reversed by the new Labour government that came to power in 1998, however. As figure 4.1 shows, care provision has continued to shift towards the independent (private and voluntary) sector, which now accounts for the bulk of care provision. While the total number of households receiving home help services decreased from some 400,000 in 2000 to 335,000 in 2007, this decrease has been accompanied by a strong increase in the number of hours of care received per household, from 7.0 hours on average in 2000 to 11.6 hours in 2007 (The Information Centre 2008: 3, 5).

Figure 4.1: Number of households receiving publicly organised home help services provided by Local Authorities and private and voluntary organisations



Source: The Information Centre (2008: 5)

Table 4.1 confirms the gradual decrease in the number of people aged over 65 who receive publicly funded or publicly organised services. In the most recent year (2007-08) 5.8 percent of people in England aged 65 and over received home care services. In total 3.3 percent were in residential care facilities: in the independent sector (1.9 percent), in local authority settings (0.3 percent) or in nursing homes (1.1 percent). These figures are slightly lower than those reported in table 1.5, because the figures in table 1.5 also include privately funded services.

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Table 4.1: Estimated percentage of people aged 65 and over receiving publicly organised services during the year by service type, England[1]

	2005-6	2006-7	2007-8
Home Care	6.1	5.9	5.8
Day Care	1.7	1.6	1.5
Direct Payments	0.2	0.2	0.3
Residential care:			
Independent sector residential care	1.9	1.9	1.9
Local Authority staffed residential care	0.3	0.3	0.3
Nursing care	1.2	1.2	1.1

Source: The Health and Social Care Information Centre (2008: 6)
Services were provided, purchased, or supported by Local Authorities
[1] Percentages are own calculations based on estimates of the number of people aged 65 and over living in England according to UK National Statistics.

Local authority provision and financing of social care services is tied to a set budget, designed to increase with economic growth (Baldock 2003: 120). Local authorities manage the budgets and can decide on eligibility criteria and means-tests for home care services. On the contrary, national rules regulate how income and assets are taken into account and how charges are calculated for residential care (Wanless 2006: 18). In principle, local authorities have to organise care services for anyone in need of long-term care services. Depending on the income of the person in question, the client has to contribute financially towards the services provided by the local authority. The financial means of other relatives are not taken into consideration (Saraceno and Keck 2008: 18). The out of pocket contributions of clients can mount up to the total costs of the service, at which point the role of the local authority is nothing more than that of a mediator. In 2006-07 councils recovered 46 percent of gross residential care costs through charges of recipients, but only 10 percent of home care costs[36].

In practice, many people do not go through Local Authorities when they are in need of long-term care. Instead, they buy their provisions directly on the market. For example, in 2007-08, 146,000 older and disabled people living in care homes were paying fees privately and directly to the care home. Many other people 'topped up' the help they received from their local council by buying additional private services (CSCI 2009: 2).

Recently, Direct Payments have been introduced. These payments are transferred to the person in need of care; the level depends on the care needs of each person. The payments can be spent according to the recipients' will, but the recipient has to account for the spending.

[36] Compared to the years before, the percentage of costs recovered through charges overall had decreased, due to increased national coordination of charging (CSCI 2009)

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Although the Direct Payments are still not very widespread, they are growing. By March 2008, 73,540 people received Direct Payments (CSCI 2009: 2). Independent of these direct payments and other care services, all dependent older people receive an Attendance Allowance of between 170 and 255 pounds, which is not means-tested and can be spent freely.

To sum up, elderly care services are partly financed through local governments on a means-tested base. For people without assets or a substantial income, the system is rather generous. On the contrary, although people who enjoy a high income or significant assets can still depend on Local Authorities to organise their care services, they have to pay for the complete costs. The provision of care services has been strongly marketised, meaning that most services are now provided by private providers.

Child care

According to Lord Beveridge, the low reproduction rate of the British community made it 'imperative to give first place in social expenditure to the care of childhood and to the safeguarding of maternity' (par. 15, Social Insurance and Allied Services, Report by Sir William Beveridge, November 1942, cited in Baldock 2003: 128). This does not mean, however, that Beveridge made public provision for childcare and working mothers a priority. On the contrary, childcare had to be first and foremost provided by mothers, within the private home. Until the 1990s, childcare was understood primarily as protecting deprived or abused children (Baldock 2003: 135). Local authorities ran some day nurseries, but only for children defined as being 'in social need' (ibid.).

In the 1980s, under the government of Margaret Thatcher, childcare continued to be ranked very low on the political agenda. It was still considered to be a private matter. The government encouraged employers to provide day nurseries, but did not provide financial incentives for such provisions (Taylor-Gooby and Larsen 2004: 60). The only exceptions were a childcare 'disregard' introduced into the Family Tax Credit in the early 1990s, a means-tested supplement for low wage earners, and a small-scale voucher scheme for childcare services (Land and Lewis 1998: 69). These measures were supposed to stimulate the use of care services provided on the market (ibid.: 70-1).

All together, in 1997, 'the UK was near the bottom of the EU childcare league tables' (Lewis and Campbell 2007: 372). Non-parental childcare was mostly provided informally or by childminders. The situation changed under the new Labour government, which made the facilitation of combining work and care one of its top priorities. Childcare vouchers were abolished and a 'National Childcare Strategy' was set up in 1998. The strategy included free

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part-time early learning programmes for all 3 and 4 year olds, the expansion of childcare tax credits, and a Sure Start programme for children in disadvantaged areas (Lewis and Campbell 2007: 372). These ideas were implemented over the subsequent ten years through massive public investments.

By 2008, all 3 and 4 year olds were entitled to up to 2.5 hours of early education per day, which could be provided by public or publicly subsidised private nurseries. A childcare tax credit can be claimed by parents who spend money on a place in a nursery or on a registered childminder. Currently, families with an income up to around 35,000 pounds can enjoy the benefit. Investments in Sure Start programmes have continuously increased and children's centres have been set up, within which services for children – nurseries – and for their parents – schooling, support with job seeking, etcetera – are combined. With the introduction of the 2006 Childcare Act, a statutory duty was placed on local authorities to ensure that childcare was sufficiently available (Lewis and Campbell 2007: 372).

Table 4.2 below shows the use of childcare arrangements by children aged 0 to 12 when the adult responsible for the child is at work. Unfortunately, data are not available for more specified age groups. Therefore, the data in table 4.2 cannot be compared with the data presented in table 1.5. Nevertheless, table 4.2 gives some interesting information. It shows, first of all, that the use of day nurseries has increased substantially in the last decade in Britain, from 4.8 percent of all 0-12 year olds in the early 1990s to 9.2 percent in 2006. Simultaneously the use of nannies increased to 3.3 percent of children aged 0 to 12 in 2006, while the percentage of families hiring a formal childminder decreased slightly to 6.0 percent in 2006. The last column of the table shows the average monthly income of households making use of a particular type of childcare. It appears that those households employing a nanny or childminder earn more than households using a day nursery, who in turn earn more than households who rely on a spouse or partner, relative or friend for childcare.

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Table 4.2: Percentage of all children aged 0 – 12 in different childcare arrangements[1] and monthly income of households using different childcare arrangements.

	Average 1991-1995	Average 1996-2000	Average 2001-2005	2006	Monthly income, 2006[2]
Spouse or partner	22.9	20.1	19.2	17.3	£3171 (229)
Nanny/mother's help	2.1	2.5	2.7	3.3	£3858 (44)
Workplace nursery	0.7	0.5	0.8	0.7	£3371 (9)
Day nursery	4.8	6.7	8.1	9.2	£3648 (122)
Child minder	7.8	8.0	7.1	6.0	£3949 (79)
A relative	17.8	21.0	22.6	21.4	£3176 (283)
Friend/neighbour	3.4	3.2	1.8	1.1	£3327 (15)

Source: British Household Panel, own calculation, weighted data.
[1] Reported use of services when the adult responsible for the child is at work.
[2] Average household income per month in pounds, number of respondents answering income question between brackets.

In conclusion, public investments in childcare services have increased, as well as the tax credits for parents buying formal childcare on the market. While public services such as the Sure Start programme are specifically intended for poor families, the tax credits are also payable only to families earning less than a maximum income. Hence, public investments in childcare are means-tested and targeted at lower and middle income groups.

Immigration

Immigration to Britain is strongly shaped by its colonial history. In the first decades after World War II, British immigration policies were very liberal for (former) colonies. The 1948 British Nationality Act established that all citizens of countries within the British Commonwealth[37] had the right to reside in Britain. The same applied to Irish citizens, even though Ireland had left the Commonwealth in 1948. Freedom of movement also applied to citizens of Britain's overseas colonies. Most of the Commonwealth citizens who migrated to the UK were economically active and did not intend to stay in the country (Messina 2007: 108). In addition, some immigration from Poland and other European countries was encouraged, because immigrants from these countries were seen 'as valuable recruits to alleviate the severe labour shortages

[37] The Commonwealth was formed in 1931. Its first members were the UK, Canada, Australia, New Zealand, South-Africa, Ireland and Newfoundland. In 1947 India, Pakistan and Sri Lanka joined the Commonwealth. In the 1950s and 1960s a large number of former colonies in Africa, south-east Asia and the Caribbean joined.

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caused by post-war reconstruction' (Layton-Henry 2004: 301). Among the immigrants from the Commonwealth was a large group of nurses recruited overseas (Solano and Rafferty 2007).

Two Commonwealth Immigrants Acts in 1962 and 1968 and an Immigration Act in 1971 put an end to Britain's liberal immigration policy. They were the result of a political campaign to control non-white immigration (Layton-Henry 2004: 301). The laws restricted the inflows of Commonwealth citizens and British citizens were only free to move if their parents were born in the UK, the so-called 'patriality principle' (Layton-Henry 2004: 302). Unrestricted entry – in response to a pro-Commonwealth lobby in Parliament – was granted for family reunification (Messina 2007: 109).

Organized political opposition to migration emerged early in the UK. The National Front was founded in 1967 in response to the neglect of race-related issues in mainstream politics (Messina 2007: 56). The conservative parliamentarian Enoch Powell gained a lot of support after his speech in 1968 in which he warned of future racial conflicts and infamously predicted 'rivers of blood'. When Margaret Thatcher became the new leader of the Conservative Party, the party chose a strongly restrictionist approach to immigration (Layton-Henry 2004: 303). This pacified the immigration debate, probably because the new Conservative government elected in 1979 was 'openly hostile to immigrants and […] promised further immigration restrictions' (Messina 2007: 114), which undercut support for more extremist parties. The British Nationality Act of 1981 established a new citizenship policy, which distinguished between British citizens and those of dependent and overseas territories. Later in the 1980s visa requirements were introduced, first for Sri Lankans and later also for Indians, Pakistanis, Nigerians, Ghanaians, and other nationalities (Layton-Henry 2004: 306-7). Throughout this period, the work permit system facilitated the immigration of doctors, nurses and related health professions (Cangiano et al. 2009: 37).

The relative tranquillity on the issue of immigration disappeared in the early 1990s, partly as a consequence of the Rushdie affair – which brought issues of Muslim integration to the public's attention – and partly due to a large influx of asylum seekers (Layton-Henry 2004: 309; Messina 2007: 115). Contrary to earlier political silence on the issue, the Conservative opposition now openly criticized the Labour government for being too 'soft' on 'bogus asylum seekers' (Messina 2007: 115). The Conservative Party made the asylum issue central to their political campaign in 2005, but without much success.

The 1997 Asylum and Immigration Act made it illegal for employers to knowingly or negligently employ irregular immigrants. According to Layton-Henry these measures have not been very effective and there have been only a small number of successful prosecutions (Layton-Henry 2004: 325).

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The buoyant economy in the 1990s caused 'significant and sustained labour shortages for both skilled and unskilled workers' (Layton-Henry 2004: 297). Under the Labour government that came to power in 1997, the number of work permits issued significantly increased (Layton-Henry 2004: 324). After EU enlargement in 2004 the government decided to immediately open its labour market for citizens of the new Central and Eastern European member states (the 'A8'). The government recognised the potential economic benefits at a time of low national unemployment and skills shortages within the national labour market (Smith 2008: 418). In the less than five years between the opening of the labour market in May 2004 and March 2009, almost a million (989,085) A8 citizens were registered as workers in the UK[38]. Almost two thirds of these were Polish, followed by Slovaks and Lithuanians (UK Border Agency 2009b). In 2006 the number of work permits granted to non-EEA citizens was 141,000. The largest share was given for work in computer services (22 percent), followed by health and medical services (18 percent). 37 percent of all permits went to Indians (OECD 2008a: 286).

Meanwhile, the most common route for permanent immigration is for reasons related to family unification. In 2006, 109,000 migrants received a permit to stay for family reasons. Another important route is asylum, although the number of permits issued for humanitarian reasons halved in 2006 in comparison with the previous year (in 2005, 67,800 permits were issued for humanitarian reasons). It should be noted that compared to Italy, many more immigrants in the UK obtain the British nationality. Between 1997 and 2008 on average 3.8 percent of foreigners in Britain naturalised, compared to only 0.9 percent in Italy.

In 2007 a new points-based system was introduced to regulate labour immigration. Labour migration was to be subdivided into five different tiers. Tier 1 is for highly skilled migrants who can enter the country if their level of education and previous income are sufficiently high. Tier 2 is for skilled migrants, whose work permits depend on labour market shortages, on how skilled their future work is deemed to be, and on their future income. Within tier 2 falls the work permit for 'senior care workers'. Tier 3 is for low-skilled occupations and has been closed for the moment, because sufficient numbers of low-skilled workers are expected to come from Eastern Europe. Tier 4 applies to students and tier 5 to a variety of other categories. To this last tier belongs also a special scheme for migrant domestic workers. Foreigners migrating to the UK can, under certain circumstances, bring their domestic workers with them. Once in the UK, these foreign domestic workers are allowed to change employers. This permission was granted after extensive lobbying, as will be discussed in the last part of this chapter.

[38] Of course many of these might have also left the UK in the mean time.

4.2 Migrant workers in social care

Agency-based employment of migrant workers

According to the UK Labour Force Survey (2008, 4th quartile), 14.2 percent of the total labour force in England[39] is foreign born (see table 4.3). Foreign born workers are overrepresented among 'care assistants and home carers', making up 20.7 percent of the people employed in this sector. Even larger is the share of foreign born workers in the group of 'childminders and related occupations', with 23.1 percent. Among nursery nurses (working in day care centres for children), on the contrary, foreign born workers form only 6.7 percent of all workers. When taking into account foreign nationals instead of foreign born employees, a similar picture emerges. The share of foreigners working as care assistants and childminders is also higher than their share in the total workforce. Estimates based on the Labour Force Survey suggest that around 120,000 foreign born workers were working as care assistants, and there were around 22,000 foreign born childminders. It should be noted that these numbers are likely to be underestimates of the real numbers, because migrant workers are usually underrepresented in Labour Force Surveys (Cangiano et al. 2009). In their survey of elderly care providers (residential and home care) in the UK, Cangiano et al. found that 19 percent of the employed care workers were foreign born. Of those who started working in the year preceding the survey (i.e. in 2007) this percentage increased to 28 percent (Cangiano et al. 2009: 58).

Table 4.3: Foreign born and foreign nationals as percentage of all employed and estimated total numbers, by selected occupation and in total labour force, 2008, England

		Care assistants and home carers	Nursery nurses	Childminders and related occupations	Total labour force
Foreign born	As % of workforce	20.7	6.7	23.1	14.2
	Estimated Nr.	121,564	9,726	22,540	3,516,807
Foreign national	As % of workforce	14.0	3.2	18.7	8.7
	Estimated Nr.	82,568	4,609	18,230	2,140,530

Source: UK Labour Force Survey 2008 – 4, own calculations, weighted data

The labour force data reveal that, on average, foreign national care assistants and nursery nurses had been in the country for 8 years, while foreign childminders arrived more recently, having lived in the UK for only 4 years on average [40]. Table 4.4 shows the average number of years for

[39] In this section 'England' explicitly refers only to the region of England within the UK.
[40] It should be noted that these figures have a limited reliability, since the number of migrant workers in the survey is rather small, especially for childminders and nursery nurses.

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which care assistants of different origins had lived in the UK. The number of foreign childminders and nursery nurses include in the LFS were too low for a similar table. As can be seen in table 4.4, on average foreign nationals had resided in the UK for a shorter period than foreign born care assistants. This is related to the fact that it is relatively easy for foreign born immigrants to obtain the British nationality. Because foreign nationals have on average arrived more recently, and because they have by definition a legal status that differs from British workers, the data analyses hereafter will focus on immigrants with a foreign nationality.

Table 4.4 also shows that the number of years for which migrant workers from different nationalities had lived in the UK differs substantially. While migrant workers originating from the Anglophone Caribbean had resided in the UK for 20 years on average (foreign nationals), foreign workers from Eastern Europe, the Philippines and the Indian subcontinent had resided in Britain only for 3 to 4 years.

Table 4.4: Average number of years lived in the UK for foreign born and foreign national care assistants and home carers, by region of origin

	Foreign nationals	Foreign born
Anglophone Caribbean	20	28
EU15 + Norway	20	29
African Commonwealth[1]	7	9
A8[2]	4	8
Philippines	3	4
Indian subcontinent[3]	3	14

Source: UK Labour Force Survey 2008 – 4, own calculations, weighted data
[1] Botswana, Cameroon, Gambia, Ghana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Nigeria, Seychelles, Sierra Leone, South Africa, Tanzania, Uganda, Zambia, Zimbabwe.
[2] Nationals of the member states that joined the EU in 2004, minus Cyprus and Malta. A8 = Poland, Estonia, Latvia, Lithuania, Hungary, Czech Republic, Slovakia, Slovenia.
[3] India, Bangladesh, Pakistan, Sri Lanka.

Table 4.5 compares the regions of origin of foreign national care assistants and childminders. Nursery nurses could not be included because their numbers were too low. The regions of origin of the two reported groups are quite different. Citizens from the eight Eastern and Central European countries that joined the EU in 2004 – hereafter referred to as 'A8'[41] – form with 30.7 percent by far the largest category of foreign nationals working as childminders or in related occupations, followed by Romanians and Bulgarians – hereafter referred to as A2. By contrast,

[41] Poland, Estonia, Latvia, Lithuania, Hungary, Czech Republic, Slovakia, Slovenia

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the largest group of immigrants working as care assistants came from African countries that formed part of the Commonwealth of Nations[42], with 26.7 percent. Within this group, Zimbabwe was the most important country of origin. The second largest group – and the largest as a single country – consists of Filipinos, who make up 15.9 percent of the foreign care assistants. It should be noted that in all these countries, English is an official language.

Table 4.5: Foreign care assistants and childminders by nationality as percentage of all foreign workers in selected occupation, 2008, England

	Care assistants and home carers	Childminders and related occupations	Total labour force
EU-15 & Norway	15.3	15.3	23.3
A8[1]	11.4	30.7	18.2
A2[2]	1.3	15.5	2.3
Indian subcontinent[3]	12.4	2.7	13.8
Philippines	15.9	3.7	2.5
African Commonwealth[4]	26.7	10.9	11.5
Latin & South America	1.2	12.7	3.2
Anglophone Caribbean	6.4	0	1.7

Source: UK Labour Force Survey 2008 – 4, own calculations, weighted data.
[1] See footnote [2] in table 4.4.
[2] Romania and Bulgaria.
[3] India, Bangladesh, Pakistan, Sri Lanka.
[4] See footnote [1] in table 4.4.

In 2004, the UK granted employees from the new EU accession countries, known as the 'A8', free access to the British labour market. The only thing requested was a formal registration when starting to work in the country. Figures on these official registrations of workers from the A8 show that approximately 2.6 percent of all those who registered between July 2004 and December 2008 were care assistants and home carers, amounting to 23,015 in total (UK Border Agency 2009a: 15). Though this is a significant number, the occupation is far from the most popular in the UK and is overshadowed by process operatives, packers and kitchen and catering assistants. In the same period, 1,405 A8 nationals registered as childminders. Table 4.6 shows that the number of A8 nationals seeking employment as care assistants and home carers has actually declined, both in absolute terms and as a percentage of all A8 entrants.

[42] The Commonwealth of Nations is an organisation of 53 countries, most of which at some point were part of the British Empire.

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Table 4.6: A8[1] workers that registered as care assistants or home carers, per year, absolute number and percentage of all A8 workers

	2004	2005	2006	2007	2008
Care assistant and home carers	2580	6880	6285	4340	2930
As % of total	2,96	3,36	2,76	2,06	1,87

Source: UK Border Agency (2009a)
[1] See footnote [2] in table 4.4.

Cangiano et al. show that migrant workers are often working in London, where they form more than 60 percent of the care workforce, followed by the South East of England. The prominence of migrant care workers in Scotland and Wales and the in north of England is much smaller (Cangiano et al. 2009: 72). The same researchers also estimated a breakdown of the different immigration statuses held by migrant workers. They estimate that of all foreign born care workers, 28 percent held British nationality, while 20 percent were allowed to work in the UK because they were EU nationals. In addition, 19 percent were dependent on a work permit, 9 percent had student visas, and 14 percent had indefinite leave to remain (ibid.: 67).

The figures cited above show that migrant workers have started to play an important role both as care assistants and childminders, but not as nursery nurses. An open question is still who employs these care assistants and childminders. In the analysed Labour Force Survey, a large majority of care assistants and home carers report to be working in 'health & social work', while only slightly more than 1 percent reports to be working for 'private households with employed personnel'. Among the latter there is not a single migrant worker. Of all childminders, 13.8 percent report to be working for private households. Among migrant workers, this percentage rises to 37 percent. Since it is likely that a Labour Force Survey underestimates the number of (migrant) workers employed directly – declared or undeclared – by families, this suggests that there might be a considerable share of foreign nationals employed as childminders or nannies directly by families. I will come back to the private employment of migrant care workers below.

Finally, Moriarty et al. note that '[r]ecent press reports have suggested that there is a high level of illegals working in care homes, although the care homes sector would dispute this' (Moriarty et al. 2008: 15). There is very little known about the employment of irregular immigrants. In their qualitative interviews with care workers, Cangiano et al. came across migrant workers who had been irregularly living in the UK or were not allowed to work for a certain period, for example because they were awaiting a decision on their asylum application, or because they had overstayed their student or tourist visa. In these periods they nevertheless found employers willing to hire them irregularly (Cangiano et al. 2009).

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Migrant workers in private employment

The LFS data discussed above suggested that a large number of migrant workers were directly employed by private households as childminders or related occupations, while hardly any care assistants or home carers were reported to be directly employed by a private person. It is questionable whether the LFS data adequately describe employment by private households. Unfortunately there are no other quantitative sources available. Therefore, to better understand the market of privately employed migrant workers, we have to take a closer look at some other qualitative and anecdotal evidence.

In research on migrant childcare workers, Williams et al. found that Eastern Europeans, in particular, have started to work as nannies in greater numbers. They quote an agency manager, who said:

> *This has changed the nanny world: they are willing to combine childcare with domestic work. […] Now employers can get childcare and cleaning for less than £9 per hour – they love it! (Lister et al. 2007: 143)*

Indeed, having a look at websites that advertise nanny jobs, the number of Eastern Europeans in the database offering their services is high, especially among those who are willing to combine childminding with housekeeping tasks[43]. These findings, in line with the large numbers of Central and Eastern European childminders in the Labour Force Survey, suggest that the number of migrant nannies from Eastern Europe has increased substantially in the past years. Yet less than 2000 A8 nationals have officially registered as childminders, as was reported above. This suggests that many take up this job without any formal registration.

Regarding elderly care, there is less evidence of a vibrant market for private migrant carers. The phenomenon has not had as much attention as the employment of migrant workers in private childcare or agency-based elderly care (Gordolan and Lalani 2009). But this type of work does exist. Kalayaan, an organisation for migrant domestic workers, investigated the experience of migrant elderly care workers. Researchers interviewed 50 migrant care workers. The four most important countries of origin were the Philippines, India, Zimbabwe, and Sri-Lanka[44]. Among those who reported their type of living arrangement, slightly more than half lived-in with their employer. Most care workers had a regular status. Only two were undocumented, 18 had domestic worker visas, 9 had obtained indefinite leave to remain, and 7 used student visas. There is a range of organisations offering mediation for the employment of

[43] Source: http://www.nannyjob.co.uk/, accessed in May 2007 and again in August 2010. In 2010 the number of Eastern Europeans in the database had decreased, except for the number of Romanians.
[44] Some interviewees were contacted through Kalayaan, others through a snowballing method. As a consequence, the data are not completely representative.

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private care workers[45]. On a website of one such organisation, it is reported that migrant care work is especially popular among:

> *[...] working holiday makers from Australia, New Zealand and South Africa, although many new carers are coming to England from countries in the European Union, like Poland, Spain, Slovakia and others*[46]

Although migrant elderly care work clearly exists, organisations in the field do not believe it has become very important yet (yet)[47]. For example, a Kalayaan researcher involved in the study on elderly carers asserted that it was still more common to find migrant workers providing childcare services.

Table 4.7 summarises the findings of this section. Unfortunately, some of the findings are based only on qualitative and anecdotic evidence, because no better data were available. Nevertheless, the combination of the UK Labour Force Survey, secondary material and the information obtained through interviews all point in the same direction: migrant workers are important in formal agency-based elderly care, but not in agency-based childcare. Families regularly employ a migrant worker as childminder or nanny, but less often as elderly carers. How often this private employment is irregular or undeclared we do not really know. Some agencies might employ migrant workers irregularly, but again, little is known about the magnitude of this phenomenon.

Table 4.7: Types of employment of migrant workers in social care in England

		Employer	
		Agency	**Household**
Employment relationship	**Formal**	*Elderly care: high* *Childcare: low*	*Elderly care: some* *Childcare: high*
	Informal	*Elderly care: some?* *Childcare: unknown, probably low*	*Elderly care: some* *Childcare: high?*

[45] See, for example: http://www.uk-care.com/index.html, http://helpinghandshomecare.co.uk/the-carers/ and the websites mentioned in the following footnotes.
[46] http://www.liveincarers.com
[47] As recounted in interviews with Age Concerns, Kalayaan and the National Care Association (NCA).

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4.3 Explaining reliance on migrant workers in agency-based and private care

As we have found above, migrant workers are overrepresented among home carers and care assistants in agency-based employment, underrepresented as nursery nurses, yet again overrepresented as childminders and nannies, and probably less common in private elderly care. Why are migrants working in the above described sectors? The section below starts by discussing what is known about the employment conditions in the social care sector in general, and those of migrant workers in comparison with native workers. Subsequently, the effect the English child and elderly care system has upon the demand for migrant workers will be assessed. The last part then looks at the impact of immigration policies.

Working conditions of British and foreign workers in agency-based care

This section sets out the employment conditions in social care, and compares the situation of native and migrant workers wherever possible. The first thing to be considered is pay. Expectation A1, formulated in chapter 2, asserted that migrant workers are possibly employed that are characterised by low pay. Cangiano et al. note that social care 'is identified as one of the sectors of the UK economy where low pay is common' (Cangiano et al. 2009: 82). Yet they also point out that it is one of the sectors for which the introduction of the National Minimum Wage in 1999 has made a difference. Cangiano et al. compared the distribution of wages reported by UK-born care workers, recent immigrants, and non-recent immigrants, based on Labour Force Data of 2007 and 2008. They found that recent immigrants (having arrived in the UK less than ten years before the time of the survey) more often earned less than 6 pounds an hour than non-recent immigrants and native workers (ibid.: 82). It should be noted, however, that these recent migrants were also much younger than the two other groups, which might have contributed to the pay differences (ibid.: 68).

In order to control for the potential effect of age on wage differences between native and foreign employees, I carried out a very simple regression analysis. In a sample consisting of care workers, nursery nurses and childminders, the independent dummy variable of 'British or foreign national' has a very small (and insignificant) negative effect on pay (see table 4.8). However, as soon as we include age as a control variable, the negative effect becomes positive (but insignificant). When a variable describing the highest level of education obtained by the worker is also included, the effect of being a foreign national becomes even more positive (though still insignificant). The results are very similar when the dummy variable on nationality

is replaced with a dummy that distinguishes being a recent immigrant or not. Based on this simple analysis, there is no evidence that migrant workers are paid less than native workers.

Table 4.8: Regression analysis, dependent variable is gross hourly pay, coefficients are standardized

	Model I	Model II	Model III
Nationality British or other (1 = other)	-0,007	0,010	0,021
Age	-	0,207*	0,243*
Highest obtained education	-	-	0,236*

Sample consists of employees in three selected occupations: home care worker or care assistant, nursery nurse, and childminder.
N = 388
*significant at 0,01 level
Data source: Labour Force Survey 2008/4, own calculation, unweighted data

Table 4.9 compares some of the characteristics of employees in different social care occupations. When comparing pay in the different care sectors, it is striking that hourly pay is worst among nursery nurses (£7.22, compared to £7.41 for care assistants and £8.62 for childminders), which is the occupation in which the smallest number of migrant workers was found. The low pay of nursery nurses is probably related to the fact that nursery nurses are on average much younger than those working in other occupations (see table 4.11). But it should be concluded that pay is apparently not the main explanation for employing migrant workers. Migrant workers are not paid worse than others, and they are not overrepresented in the worst paid care occupation.

Table 4.9: Some job characteristics of workers in different occupations, 2008

		Care assistants	**Nursery nurses**	**Childminders**
Gross hourly pay in pounds	All	£7.41	£7.22	£8.62
	Public sector	£8.48	£8.85	£10.63
	Private sector	£7.02	£6.24	£8.44
Percentage working	In the public sector	26	34	5
	Full-time	58	57	55
	Night-shifts	27	2	3
Usual hours worked	Excluding overtime	30.2	30.2	31.8
	Including overtime	40.9	32.7	36.7
Union membership percentage		20	20	12

Source: LFS 2008-4; own analysis; non-weighted data

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What then about other employment conditions? Care assistants most often reported to work night-shifts. As can be seen in table 4.9, of all care assistants, 27 percent reported to regularly work night shifts, compared to 2 percent of nursery nurses and 3 percent of childminders. Care assistants also work more hours when overtime is included. Childminders are least often member of a trade union.

Only for care assistants the number of respondents in the Labour Force Survey is large enough to compare employment conditions of British and foreign workers. As can be seen in table 4.10, there are a number of things that stand out. First, foreign nationals are less often employed in the public sector (17 percent compared to 28 percent of British workers). This finding is confirmed in other studies (Cangiano et al. 2009). Jobs in the private sector are not only paid less (as can be seen in table 4.9), but they also fall behind when comparing other employment conditions, such as holiday and maternity leave entitlements, sick pay and pension provisions (Land and Lewis 1998: 63).

Besides, foreign nationals are less unionised, with 13 percent of them who are members of unions versus 21 percent of British workers. Foreign care assistants work full-time more often and, consequently, work more hours; though they do not do more overtime work. A very striking difference, finally, can be found in the number of respondents reporting to have worked night-shifts. While only 22 percent of British workers reported to have worked night-shifts, this percentage was 61 percent for foreign workers.

Table 4.10: Differences in job characteristics for British and foreign care assistants and home carers, 2008

		British	Foreign national
Percentage working	In the public sector	28	17
	Full-time	56	73
	Night-shifts	22	61
Usual hours worked	Excluding overtime	30	33
	Including overtime	41	43
Union membership percentage		21	13

Source: LFS 2008-4; own analysis; non-weighted data

To make the picture complete, it is interesting to look at the reasons why employers opt to employ a migrant worker. Cangiano et al. one important reason for hiring a migrant worker given by employers was the difficulties they had with recruiting UK workers (Cangiano et al. 2009: 91). The employers in the study pointed out that this was the case partly because UK

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workers can earn more in other jobs. Additionally, British workers were less willing to do shift work and found that too few opportunities existed for promotion (ibid.: 92-3). The most important advantages of employing migrant workers, according to employers, are that they are willing to work all shifts, more willing to learn new skills, and have a good work ethic (ibid.: 93). The main disadvantage of hiring migrant workers is that they sometimes have a poor command of the English language (ibid.: 96). The latter, of course, only applies to migrants whose mother tongue is not English. The fact that English is a language spoken by so many people has undoubtedly facilitated the employment of migrant workers in social care.

The data described above suggest that foreign care workers are not necessarily worse paid than their British colleagues. However, among care assistants and home carers, foreigners work longer hours, are more often employed in the private sector, and – most notably – are much more likely to work night-shifts. The willingness of foreign workers to work all shifts, with a 'good work ethic', for the low pay available, is what makes them attractive for employers. These findings are largely in line with expectation A1, that asserted that migrant workers are overrepresented in 'bad' jobs, characterised by unpleasant working conditions.

Care regime and migrant labour

Above we have seen that migrant workers are employed in elderly care services because employers have difficulties finding native workers due to poor employment conditions, especially in the private sector. These poor employment conditions are partly shaped by public policies. Expectation A4 claimed that public investments crowd out the demand for migrant workers. A lack of public funding could hence increase the demand for migrant workers in the social care sector. As described in section 4.1, the shift to the private sector has been an explicit policy aim in the past decades. Moreover, the amount of funding from local authorities also plays an important role in setting the standards for the private sector. As an employer interviewed by Cangiano et al. put it:

> *If we could pay twice the minimum wage, then we would attract more local staff, and they would be more prepared to work those hours. But our funding is from the Local Council. 80 per cent of our clients are funded totally by the local council (Cangiano et al. 2009: 92).*

The Local Authority decides on the price it will pay for a bed in a care home, the care provider then has no choice but to provide the service for that price. Indirectly, this policy is hence partly responsible for the demand for migrant workers. Although there have been several public initiatives to improve working conditions in the social care sector, as will be further discussed below, the current system with limited public funding and market outsourcing seems to

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contribute directly to the poor working conditions and the employment of migrant workers in agency-based care.

Meanwhile, public services are targeted at lower income groups. Public provision in the English elderly care sector is highly means-tested. While those with a low income and no assets can rely on free services, user fees increase steeply with income, until they cover the entire cost of the services. Older people who are better-off therefore have to pay for their own care services. We have seen before that these elderly often purchase these services on the formal market. For example, they pay privately for a place in a nursing home. This leaves us with the question why British elderly do not rely on private care workers more often. Considering that Italian families paid around €800 for their private migrant care workers, British well-off elderly could also afford such a construction. Eurobarometer opinion data show that British people dislike long-term care institutions just like all other Europeans. Only 5 percent of survey respondents would like to be looked after in a long-term care institution compared to 9 percent on average in the EU-15 (Appendix table A-4). So why do English elderly not opt for a private care assistant more often?

An explanation for the limited reliance on private care workers could be cultural. The Italian migrant in the family model of care heavily depends on the involvement of family members. Historians have shown that older people in the UK and other Northern European countries have lived relatively independent of their children compared to older people in Southern Europe (Smith 1984; Reher 1998). That older people in the UK still live more independently from their family can be derived from the Eurostat data presented in Appendix table A-1. While 13 percent of men aged over 65 and 15 percent of women in the same age group lived together with others than their spouse (i.e. in most cases with their children), in Italy the same applied to 32 percent of men and 29 percent of women. SHARE data presented in the same appendix table show that 42 percent of Italians aged over 80 live with or in the same building as their child. Unfortunately these share data are not available for the UK, but Grundy showed that in 1991 only 21 percent of women aged 85 years and over in England and Wales lived with their children (Grundy 1999). This relative independence of older people from their children is translated into different expectations regarding the role of children when attendance is needed. Only 24 percent of British people expect children to pay for care services, compared to 68 percent in Italy, and 30 percent thinks care should be provided by relatives compared to 48 percent of Italians (Appendix table A-4). Hence, it could be that the employment of a private care assistant and the necessary involvement of family members in this arrangement does not fit with the relative independence of the English elderly. This option will be further discussed in chapter 6.

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Attention should be paid, finally, to recipients of Direct Payments. Expectation A5 proposed that cash allowances, especially when unregulated, would lead to a demand for private informal migrant care workers. It should be remarked, first of all, that Direct Payments are in fact not very popular among the elderly. In 2006/07 only 17,000 people aged over 65 received Direct Payments (Glasby and Littlechild 2009: 54) Local councils spent on average £5,400 per Direct Payment recipient aged over 65 per year (CSCI 2009: 26). Recipients have to account for how Direct Payments are spent. Therefore, the money can only be used to regularly hire a care worker. A survey of the care assistants employed through direct payments showed that two thirds of them already had experience working in the care sector (IFF Research 2008: 77). Reasons for working as a personal assistant included enjoying the work and the flexible working hours. Of all 486 care assistants that participated in the survey, 92 percent were white (IFF Research 2008: 73). In conclusion, Direct Payments do not seem to contribute directly to the increased employment of migrant care workers.

So far we have seen that the lack of public funding and the marketisation of the social care sector have contributed to a demand for migrant workers in agency-based care. Private (informal) care is less common, for which a cultural explanation has been given. There is no evidence that Direct Payments have increased the demand for private (informal) migrant care workers. Each of these issues will be further discussed in a comparative perspective in chapter 6.

Childcare

The proportion of migrants employed as nursery nurses is particularly low. Nevertheless: 'despite significantly increased state expenditure on ECEC and an emphasis on workforce development, the ECEC workforce remains among the most poorly qualified, lowest paid and least valued of all professions in the UK' (Daycare Trust 2008: 2). Therefore, the sector also has great difficulties finding qualified employees. Why are there nevertheless so few migrant workers? Contrary to the elderly care workforce, there has not been much research on this issue. One explanation could be related to the employment conditions. Since employers in the elderly care sector had the largest difficulty finding employees willing to work 'unsocial hours', the fact that these unsocial hours are not required in the childcare sector could be an important difference.

Second, there are more career opportunities for nursery nurses. Table 4.11 summarises the average age and education of British and foreign care workers. As can be seen, nursery nurses were on average younger and more highly qualified than care assistants. At a higher age,

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many nursery nurses move on to the maintained sector, i.e. state funded schools under the control of local authorities, in which pay and employment conditions are much better. A civil servant said:

> *We know that we're putting a lot of people through the system in terms of early years professional status and we're training a lot of people, but we're worried that we're not retaining the people with that status. So either they're going on to another job, or they're going on to work in the maintained sector which [has] a higher status than the childcare sector (Interview Department of Families).*

This is a concern for policy makers. Yet the very fact that there are such opportunities might make it easier to find people willing to train for and work in the childcare sector.

Table 4.11: Average age and percentage with professional education (NVQ 3 or above[1]) of British workers and foreign nationals for different occupations, 2008

		Care assistants	Nursery nurses	Child-minders
Average age	All	42	33	38
	British	42	…	39
	Foreign nationals	39	…	31
Percentage with NVQ 3 or above[1]	All	36	58	52
	British	35	…	57
	Foreign nationals	37	…	26

Source: LFS 2008-4; own analysis; non-weighted data
Note: childminder figures should be taken with caution due to low N, but were included because results are very different.
[1] NVQs are based on national occupational standards. NVQ level 3 is a professional education, which is seen as similar to having completed two or more A-levels.

As for elderly care, public investments in childcare are means-tested and targeted at low-income families. The only universal service available is 2.5 hours of free nursery care for 3 and 4 year olds. For the rest, well-off parents have to find their own childcare solution. In a qualitative study of childcare strategies of working and middle class families, Vincent et al. found that working class parents are more likely to use nurseries (Vincent et al. 2008). Their dependence on tax credits, which are only available for formal services, means they are more constrained in their choices. Middle class families, by contrast, often preferred childminders or nannies, emphasising the personal one to one element of care. Table 4.2 confirms that parents hiring a nanny or childminder had on average a higher income. This preference for a childminder or nanny might be related to the ideal of a 'mother substitute' to care for a young child, which is still strong in Britain (Williams and Gavanas 2008).

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Table 4.11 above shows that foreign childminders were much younger and not as highly educated as British childminders. This suggests that there is a bifurcation in the sector, with one segment in which older, well-paid and highly qualified British workers work, and another segment in which younger, less-qualified foreign workers are employed. The LFS data suggest that migrant workers are much more often directly employed by families than childminders. This is in line with the quote from Williams et al. cited above, who found that the inflow of migrant workers had 'changed the nanny world'. The newly arrived migrant workers provide a new type of service, including both caring and household tasks. While there are no work permits available for childminder jobs, workers from Eastern Europe are free to be employed in any sector. Being much better paid than care assistants and nursery nurses, it seems that the job of childminder is attractive for migrants from Eastern Europe.

The impact of labour migration policies

In chapter 2, there were several expectations raised regarding the influence of immigration policy on the employment of migrant care workers. Expectation A7 regarded the impact of expansive immigration policies. In the UK, until recently, care providers could apply for a work permit for foreign 'senior care workers'. Until 2007 up to 5000 of these permits were issued every year (see table 4.13 below). However, in 2007 the eligibility criteria were changed, most importantly the new criteria included the requirement that a minimum wage had to be earned by the work permit holder. As a consequence, the number of work permits issued plummeted. The consequences of this decrease for the employment of migrant workers in the sector are not yet clear. In practice, only 19 percent of all migrant care workers depend on a work permit (Cangiano et al. 2009: 66). Other routes into the country, such as a refugee status, family reunification, or freedom of movement for EU citizens, have been equally or more important for employees in the social care sector. It is therefore questionable whether the tightened work permit criteria will have a large impact, since the other routes of entrance could guarantee a sufficiently large pool of migrant workers.

However, expectation A9 suggested that employers might prefer workers dependent on work permits. Cangiano et al. found that employees who were dependent on a work permit were more inclined to stay with their employer in the social care sector, because they had no other options. This also contributed to their willingness to accept poor working conditions. This is in stark contrast to EU nationals, who are free to enter and leave the sector. On a website of an agency facilitating work-related immigration into the UK, we can read:

> *Whilst the care industry may have benefited from the increased availability of labour from countries like Poland and Latvia, many employers have reported*

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> *that the benefits have been short lived as they freely move from job to job. Workers from the new EU member states do not need work permits and have the same choices as the resident workforce. In other words they can also opt for an easier life working for Tesco.*[48]

The quote illustrates that employees who can also opt for working in a supermarket (Tesco), might be less willing to accept the working conditions in social care. Cangiano et al. found that employers make a distinction between different nationalities: 'a high propensity to leave the job is usually reported only for East Europeans, while in contrast Filipinos are often praised for their stability within the organization' (Cangiano et al. 2009: 95). Crucially, Filipinos were usually dependent on work permits.

From the interviews Gordolan carried out with private care workers, it also appeared that they were prepared to make concessions to their employers because of their dependence on these people for their immigration status. Many care workers were in the UK on a domestic work visa. For this visa, the migrants had to give evidence of their full-time employment, for example through pay slips or a written contract. The Kalayaan researchers found that 'employers use this dependency as a means to exploit workers by paying them lower wages, refusing to give them time off'(Gordolan and Lalani 2009: 25).

Conclusion

Many of the findings in the UK case study correspond to the formulated expectations put forward in chapter 2. First, in relation to job conditions (A1), migrant care assistants are overrepresented in the private sector, where pay and social protection are worse. Migrant care assistants frequently do more night shifts than their British colleagues. Migrant childminders were directly employed by a family more often than their British counterparts and hence had a personal employment relationship with their employer.

Second, in the context of a relatively Liberal labour market regime (expectation A3), a private formal market has emerged. Nevertheless, working conditions in both the public and the private sector are directly affected by public investments, because the state is the largest buyer on the care market. Limited public investments induced a demand for migrant workers in the sector (expectation A4). Finally, a dependence on work permits made migrant workers more attractive for employers (expectation A9).

[48] Immigration Matters – The Care Industry still needs migrant workers, August 2006, http://www.immigrationmatters.co.uk/the-care-industry-still-needs-foreign-workers.html

All these factors contributing to the employment of migrant care workers will be more systematically assessed in a comparative perspective in chapter 6. This chapter now proceeds with discussing the policy responses to the employment of migrant care workers.

4.4 Policy developments: ambivalent responses

Before discussing the policy developments related to the employment of migrant care workers, let us have a quick look at the British political system. The UK has two chambers of Parliament, the democratically elected House of Commons and the appointed House of Lords. Elections take place on a district, first-past-the-post basis. As a consequence, there are only a limited number of large parties represented in the House of Commons. The two most important political parties are the Conservatives and the Labour Party. Most governments can rely on an absolute majority in Parliament.

From 1979 until 1997 Britain was governed by a Conservative government, for the first eleven years led by Prime Minister Margaret Thatcher, then followed by John Major. After a large electoral defeat in 1997, Tony Blair became prime minister for the Labour Party, followed by Gordon Brown in 2007. In 2010 Labour, lost the elections, but the result was a 'hung parliament'. The Conservatives then formed a coalition government with the Liberal Democrats.

Political power in Britain is centralised. The government is able to implement reforms quickly as there are no strong veto opportunities available to block policy making (Taylor-Gooby and Larsen 2004: 55). Since most governments can count on a parliamentary majority, opposition parties are relatively weak. Moreover, the power of interest organisations – especially the trade unions - was substantially undermined by Margaret Thatcher (Jones 2007: 265). Recent Labour governments have made a more concerted effort to consult the unions, but they continue to be weak actors in the policy making process (Jones 2007: 268). In the 1990s, finally, some political power was devolved to the regions of Scotland, Wales and Northern Ireland. Interestingly, England is the only region that does not have its own legislative assembly. Instead it is governed by the national Parliament and government.

Labour migration policies

Currently, in the UK there are two policies that directly affect migrant care workers. First, work permits are issued to 'senior care workers'. Recently the eligibility criteria for these permits were tightened. Second, special work permits are available for migrant workers who came to the UK as domestic workers accompanying their employers. Since 1998 these domestic workers are

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free to change employers. Recently the government wanted to abolish this right, but this plan was successfully challenged by lobby groups and was therefore not implemented. Before turning to these two policy areas specifically, we have to look at one development that entirely overhauled immigration patterns in the UK: the opening of the labour market to A8 citizens.

Table 4.12: British immigration policies related to migrant care work

	Direct policy responses	**Indirectly related policy developments**
Encouraging	- Work permit for domestic workers	- Opening labour market for A8[2] citizens
Discouraging	- Tightening of eligibility criteria for senior care workers - No special schemes for senior care workers from the A2[1]	

[1] The two countries that joined the EU in 2007: Romania and Bulgaria
[2] The ten countries that joined the EU in 2004, minus Cyprus and Malta. A8 = Poland, Estonia, Latvia, Lithuania, Hungary, Czech Republic, Slovakia, Slovenia.

In 2004 the British government decided to open the country's labour market to migrant workers from the Eastern European countries that joined the EU in that year (the A8). At the time, the decision was not very controversial. The economy was doing well, unemployment was low, and it was generally agreed that there was a shortage of skilled workers (Smith 2008: 418). Both the peak level business organisation CBI (Confederation of British Industry) and the peak level trade union confederation TUC (Trades Union Congress) were in favour of the removal of any restrictions on migrant workers from the A8. Although British newspapers can be very negative about immigrants, public opinion was initially relatively positive about Eastern European workers, who were expected to contribute to the British economy (ibid.: 421). Eventually, the numbers of Eastern Europeans coming to work in the UK turned out to be much bigger than originally expected, as was described in section 4.1. The mass inflow of migrant workers from Eastern Europe contributed to a negative public opinion towards migrant workers. As opinion data in Appendix table A-4 show, more than half of all Brits believe that immigrants take away jobs from native-born workers, compared to on average only 31 percent of Europeans. It is in this context, that we should understand the following discussion of policy developments.

In 2007, the British government announced the introduction of a new points-based immigration system to be implemented in steps from the 1st January 2008 onwards. While the

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system was presented as a way to curb immigration from non-EU countries (Smith 2008: 424), it was designed mostly with the aim of simplifying a very complex immigration system. There had been several scandals concerning the abuse of the immigration system[49], so there was a strong incentive to make the system more transparent and manageable:

> *It was a very politically sensitive area and government wanted to be seen to be doing something substantial to address it. Actually wanted to do something substantial to address it as well (Interview Home Office).*

The aim of the new system was mostly to manage the inflows more efficiently, ensuring that those people were brought in that were needed for the economy. The reform was preceded by an extensive consultation process which involved employers, unions, local governments and many other interest groups. Although the House of Lords and the House of Commons have debated the new system, and Conservatives have voiced critical opinions, the reform was in fact a government led process, for which parliamentary approval was not required.

In autumn 2007 the Home Office installed the Migration Advisory Committee (MAC), consisting of five economists and chaired by Professor David Metcalf. The MAC was supposed to advise the government on issues related to labour migration. Its first great task was to produce a 'shortage occupation list', indicating which sectors of the UK economy had shortages of skilled workers and whether it was 'sensible' to fill these shortages with migrant workers. In September 2008 the committee published its report, titled 'Skilled Shortage Sensible' (MAC 2008b).

The reform of the immigration system has seriously tightened the eligibility criteria for 'senior care workers'. While they were able to enter the UK in substantial numbers until 2007, the entrance of social care workers has since then almost disappeared. How this could happen will be explored in detail below. After the discussion of the 'senior care worker' permit, recent developments in permits for migrant domestic workers will be shortly considered, because these developments provide an interesting contrast with those we have seen in Italy.

Work permits for senior care workers

In June 2007 the Border and Immigration Agency[50] – an executive agency of the Home Office – put all 'senior care worker' permit applications on hold, because it was believed that:

> *Historically what's happened is that people had abused the work permit system. Or at least they've come in in quite large numbers to do jobs that are not genuinely skilled (Interview Home Office).*

[49] For example Minister Beverly Hughes lost her job over a scandal involving Bulgarians and Romanians who were given visas based on false documents.
[50] The Border and Immigration Agency was an executive agency of the Home Office. In 2008 it merged with other agencies to form the UKBA, the United Kingdom Border Agency.

Two months later the Home Office decided to tackle this alleged abuse by requesting that employers who wanted to employ migrant senior care worker had to pay these care workers at least £7.02 an hour. Besides, employers were given the task of demonstrating that the jobs they wanted to fill were skilled jobs. Following these measures, the number of work permits granted to senior care workers plummeted. As can be seen in table 4.13 below, while 4,630 migrant senior care workers still received a work permit in 2006, this number decreased to 1,005 in 2007 and to almost zero in 2008.

Table 4.13: Work permits issued to senior care workers

Year	Permits issued
2001	475
2002	2,525
2003	4,455
2004	5,720
2005	4,525
2006	4,630
2007	1,005
2008[1]	5

Source: UKBA, Home Office
Figures have been derived from UKBA management information and are provisional/subject to change. Numbers have been rounded to the nearest 5.
[1] Figures refer only to the first half of 2008.

Soon after the new restrictions were implemented by the Home Office, interest groups started to mobilise against the policy change. Amongst the organisations protesting against the new restrictions were many associations of care providers[51]. They reacted because: 'the Home Office made such a mess of the arrangements at the back-end of 2007' (Interview NCA). Staff shortages and migrant workers are becoming increasingly important for care providers. The change of policy of the Home Office was, for many providers, a warning sign:

> *People have suddenly become aware that their way of recruiting to get themselves out of really big issues about staff, is going to be closed. So it's becoming a bigger strategic issue for us (Interview NCA).*

The care providers were not alone in their concern about the work permit policy changes. While expectation C1 supposed that trade unions would take an ambivalent position, the English trade

[51] For example the English Community Care Association, the Registered Nursing Home Association, the National Care Association.

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union UNISON – the most important trade union in the social care sector – strongly opposed the new work permit restrictions. Together, business organisations and trade unions started a lobby for abolishment of the strict eligibility criteria. They briefed their branches, organised events, talked to ministers and to their local Members of Parliament. The MPs brought the issue up in Parliament. In a parliamentary debate on the 23rd of October 2007, several Labour MPs expressed their concern about the restrictions on senior care worker permits:

> *The work permit applications for senior care workers were altered in such a way that people who had been working sensibly and quietly at difficult jobs were told that their work permits would not be renewed (Mrs. Dunwoody, Labour).*

Later on the same MP wondered why the Home Office had suddenly set wage requirements. She asked whether 'the Home Office [is] now in charge of wage negotiations for people employed in private care homes'. Another MP remarked that the Home Office's policy change had led to 'uncertainty hanging over many hundreds of people who perform a vital role for the very elderly in our society' (D. Taylor, Labour). The Home Office was not unaffected by the lobby:

> *There was a major reaction from interest groups in the sector. And I think as a result of those, of that reaction, we brought in the transitional measures, which enabled people who were already here, wanting to continue their stay, to be able to move employer to do so (Interview Home Office).*

The transitional measures waved the skill-test for workers who were already in the country, but the wage requirement of £7.02 was maintained. But the sector was still concerned with the wage requirement. The discussion about permits for senior care workers was revived in 2008 due to the Migration Advisory Committee's (MAC) advice on the requirements for immigration under the new Tier 2. The MAC decided that senior care workers should only be considered skilled when they were earning a minimum of £8.80[52]. Hence only workers being paid that amount were eligible for a work permit.

Reactions of the unions and employers in the social care sector were again very strong. After a meeting with interest groups and officials from the Department of Health and the Home Office, the latter decided to refer the issue back to the Migration Advisory Committee, asking them to review their recommendation. In this review, which came out in 2009, the MAC recommended that the wage requirement should be lowered to £7.80 (MAC 2009: 92). This is still an amount substantially higher than the average wage earned in the sector.

[52] The MAC took the range of pay in the sector and combined this with data on how many employees were skilled at at least NVQ-3 level. They found approximately one third of the workforce to be skilled at this level and inferred that these should also be the best paid workers. Looking at the best paid one third of the workforce they concluded that skilled workers should be paid at least £8.80

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Meanwhile, after the accession of Bulgaria and Romania to the European Union, the British government decided to keep the labour market closed for nationals from these countries (Smith 2008: 422). In December 2008 the Migration Advisory Committee issued a recommendation on the impact of opening the UK labour market for migrant workers from the two new member states of the European Union (Romania and Bulgaria, the A2). The MAC advised negatively on opening the labour market. It argued that in the light of the current economic crisis it would be unwise to lift restrictions on Romania and Bulgaria, especially because none of the surrounding countries had yet done so. The option of opening a special scheme for social care workers from the A2 was also considered. Although the Department of Health was in favour of allowing A2 nationals to work in the sector, the MAC concluded that it was not a wise choice given the recent economic downturn (MAC 2008a: 9).

Domestic workers

Foreigners entering the UK are, under some circumstances, allowed to bring a domestic worker with them. Since 1998 these domestic workers, once in the UK, have been allowed to change employers. This was the result of a long campaign led by Kalayaan, an organisation representing these migrant domestic workers, and supported by the Transport and General Workers Union (T&G). In 2006, the Home Office announced that it wanted to end this right to change employers. Kalayaan, together with other organisations, mobilised again. Support continued to come from the same trade union, which by then had changed its name into UNITE. The alliance with UNITE was very important for the domestic work lobby: 'with regards to the Immigration Minister, having contacts with the union was really important in terms of securing meetings' (Interview Kalayaan).

However, the arguments that eventually convinced the government not to abolish the freedom to change employers had little to do with the trade union. It was also completely unrelated to a demand for domestic workers among British families. In section 4.3 the fact that most migrants employed as elderly carers were in Britain on a domestic work visa was discussed (Gordolan and Lalani 2009). Yet in relation to this family needs argument a Kalayaan representative said: 'The Home Office has just never really bought it, they just weren't interested'. What did help to convince the government was referring to the vulnerability and potential abuse of migrant domestic workers if they did not have the freedom to leave an employer. At the time, a lot of attention was devoted to trafficking[53]. By comparing the fate of migrant domestic workers to such issues, there was 'quite a lot of potential for embarrassing the

[53] Council of Europe Convention for Action against Trafficking of Human Beings

government' (Interview Kalayaan). It also made media coverage favourable 'as long as they could get stories which were about vulnerable women'. The government therefore decided not to abolish migrant domestic workers' right to change employer.

Explaining developments in labour migration policy

Policy reforms in the area of labour migration have been entirely led by the Labour government and were highly technocratic. In an extensive consultation process prior to the introduction of the new points-based system, all relevant actors were heard, but the government eventually designed the new system without much parliamentary scrutiny. When it came to deciding which migrants were sufficiently skilled to enter the country under the second tier of the new system, the Home Office installed a committee of experts (the Migration Advisory Committee). Their recommendations were adopted with hardly any exceptions.

This technocratic, a-political logic was also behind the tightening of eligibility criteria for 'senior care worker' permits. It were public officials who concluded that the system was being abused. The lobby that followed the decision to tighten eligibility criteria was only partly successful, because the Home Office was not prepared to deviate from its general line. As the Minister for Borders and Immigration put it in 2007:

> *Obviously, the Home Office cannot operate a policy under which we give work permits against our own guidance—the relevant guidance being that people need to have a certain level of skill to do the job (Westminster Hall Debate, 23-10-2007).*

When the Migration Advisory Committee advised – based on its economic analyses – to raise the pay requirements for senior care workers, this recommendation was simply adopted.

In contrast to the Italian situation, where migrant care workers have obtained a special position in the immigration system, no exceptions are made for migrant care workers in the UK. The appeal to family-needs that worked so effectively in Italy has also been invoked in the British context by both parliamentarians and interest groups, but without much success. Instead, the discussion in the UK evolved around the question of whether care work was skilled or not. In the Parliamentary debate described earlier, the laudable qualities of the care workers were repeatedly emphasised:

> *Let us enumerate the qualities of those women: they are English-speaking; they are enormously warm in their approach; and they do difficult jobs in care homes dealing with the elderly—in some cases for the minimum rates of pay (Mrs. Dunwoody, Labour).*

And:

> *The ladies at Stocks Hall nursing home do a fantastic job. They are caring, diligent and everything that one would want. The residents want them and so do*

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> *the directors, but they cannot afford to pay them £7.02 an hour (R. Cooper, Labour).*

In response, Liam Byrne, at the time the Minister for Borders and Immigration, emphasised that if the workers were truly skilled, they should earn more money:

> *My hon. Friend is right that those workers are hard-working, well integrated and doing something with a level of tenderness, expertise and care that is, in my experience, second to none. It is not unreasonable for businesses in the social care sector [...] to pay £7.02 an hour for that job (Byrne).*

Some have argued that the low wages paid for skilled workers in the social care sector is related to an undervaluing of the skills involved:

> *The problem [...] is that we believe that care is undervalued as a skill. After all it's women's work, so you know, anybody can do it, can't they, sort of thing. Whereas actually if you think about it, caring for somebody else is hugely demanding and actually requires and involves a whole range of different skills (Interview UNISON – 1).*

Nevertheless, low pay is considered to be an indicator of low skills. What is seemingly not taken into account in this reasoning is the direct relationship between public expenditure on social care and the wage levels in the sector. As a trade union representative put it:

> *The trouble with social care is, it isn't a market. It's by and large a monopoly. Something like 80-plus percent of all social care is paid for and provided by the state. So it's state funding that determines how much money is available (Interview UNISON - 1).*

Therefore, it is partly the limited public funding that determines that jobs in the social care sector are considered to be low skilled and, therefore, that migrant workers are not allowed to work in them. The decision to introduce wage requirements for senior care workers might impact upon the functioning of the social care sector. What the Department of Health's position is on this issue, and whether it has been accompanied by any changes in elderly care policies, will be explored hereafter. But before discussing the developments in elderly care, the section below will firstly address policy developments in the childcare sector.

Childcare policies

Although migrant workers play an important role as nannies or childminders, there are no direct policy responses to this phenomenon. In the past decade, childcare has received a lot of government attention. Large investments have gone into making childcare provision available for more children. Investments also went into workforce issues, especially in relation to training.

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Table 4.14: British childcare policies related to migrant care work

	Direct policy responses	Indirectly related policy developments
Encouraging		- no provisions for high income families
Discouraging		- expansion of public provision - investments in labour force issues

According to Lewis and Campbell:

> *At the level of policy settings, the changes have been transformative. The value of the child care subventions for low-earning parents was more than 16 times greater in 2004 than in 1998, having risen from £46 million to £884 million (Lewis and Campbell 2007: 372).*

The expansion of the childcare sector was initiated and driven by the new Labour government that came to power in 1997. This government saw the reconciliation of work and family life and the labour market participation of women as central issues. Childcare provision fitted neatly with New Labour's ideas of 'welfare to work' and social investment. It was seen as both an encouragement of the labour market and as a measure for poverty alleviation. Enabling both parents to work would improve a family's welfare and at the same time early education would support the development of children in disadvantaged areas.

In the actual policy making process the government organised an extensive consultation round with NGOs and other involved actors. Although interest groups in the childcare sector are usually small and not very influential, the government has made an effort to continuously include them in elaborations of new policies, because it is believed that stronger interest groups will also improve the strength of the childcare sector. During the last ten years childcare policy has continuously been expanded. Given the unitary political system and limited veto points, the government never encountered many obstacles and was able to swiftly implement reforms (Taylor-Gooby and Larsen 2004). The childcare tax credit has been expanded, entitlements for three and four year olds have been increased, and with the introduction of a new Childcare Act in 2006 local authorities have even been given the statutory duty to ensure that childcare provision in their community fulfils demand. Childcare policy is seen as 'one of the flagship policies' of the Labour government (Interview Department of Families).

In 2005, the government organised a consultation on a Children's Workforce Strategy. It had become clear that the childcare sector had difficulties with recruiting and retaining a quality workforce. Therefore, a Children's Workforce Development Council (CWDC) was established in the same year. Although labour force shortages were no 'massive national issue'

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(Interview Department of Families), it nevertheless received substantial attention because it was generally believed that a well trained workforce is vital for quality childcare (Daycare Trust 2008: 4). However, more attention has gone to training than to the actual remuneration of childcare workers in the private and voluntary sectors.

The issue of migrant workers has never received much attention in government policies. It is most salient when it comes to the provision of childcare services for the children of immigrants. Since local authorities are obliged to provide sufficient childcare on their territory, they also have to cover the needs of new immigrants. Migrant workers as childcare providers or employees are, on the contrary, of little concern. This lack of salience is related to the fact that migrant workers are usually employed as nannies or childminders for well-off families. Since British childcare policies are primarily targeted at poor families and disadvantaged neighbourhoods, these migrant workers never come into the picture. Migrant childcare workers are considered to be a private issue.

Elderly care policies

Before discussing developments in the social care sector, it should be mentioned that attracting migrant doctors and nurses to work in the NHS has been an important issue in the UK for a long time. In the 1990s it was decided that investments in the training of a native skilled workforce should be increased, in order to decrease dependence on foreign labour supply (Cangiano et al. 2009: 37). The question that this section addresses is whether a similar response to a dependence on migrant workers can be found in the social care sector.

To answer this question straight away, policy responses in the area of social care have been ambiguous. At different points in time, the Department of Health declared, first, that it did not see immigration as a viable solution for labour shortages, and second, that migrant workers from the A2 should be encouraged to work in the social care sector. Meanwhile, investments have gone into improving the skills of the native labour force. A reform of the social care sector has been on the government's agenda for a long time now, but so far without real results.

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Table 4.15: English elderly care policies related to migrant care work

	Direct policy responses	Indirectly related policy developments
Encouraging		- Marketisation of care services - Personalisation of care
Discouraging		- Some investments in native labour force - Introduction of free home care for some groups

In the United Kingdom the employment of migrant workers in the social care sector was received much less positively than in Italy. In a Department of Health publication we read:

> *[T]he independent sector has become increasingly dependent on a migrant workforce, which does nothing to improve the stability of the sector (Department of Health 2007: 31).*

According to the report, if a migrant labour force is to be employed, then:

> *[I]t is critical [...] that this is only undertaken in a careful and properly organised manner, with clear protocols and procedures in place, rather than haphazardly attracting would-be migrant workers desperate for employment even at low rates of pay (Department of Health 2007: 31).*

However, one year later, in a letter to the Migration Advisory Committee, the Department of Health argues that:

> *Restrictions on the availability of low-skilled migrant labour in the sector could result in a shortage of available workers in this sector (in MAC 2008a: 124).*

Therefore, it is argued that:

> *[A]llowing A2 labour market access could ease labour shortages in the social care sector; shortages we expect to be exacerbated under the points-based migration system [...]. Any reduction in the availability of low-skilled migration in the sector could reduce the number of available workers in this sector, with significant potential implications for Government expenditure. We would therefore welcome relaxation of A2 labour market restrictions as a route to addressing some of these concerns (in MAC 2008a: 124).*

It seems that the government is, on the one hand, not happy about the reasons for employment of migrant workers, yet on the other hand it is also not prepared to pay the price that would accompany the absence of migrant workers. As can be concluded from the previous section, the Department of Health's advice regarding A2 nationals was not followed, as they did not obtain access to social care work.

Meanwhile, the reform of the social care sector has been on the government's agenda for a long time. Already in December 1997 a Royal Commission on the funding of long-term care was set up by the new Labour government. The Commission recommended the provision

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of personal care free of charge for everyone funded by general taxation (described in Wanless 2006). A White Paper published in 1998 confirmed this commitment to improving social care. Improving people's independence and integrating different forms of care (health, home and residential) more effectively have continued to be on the agenda. However, the idea of providing services free of charge for everyone has been abandoned (Department of Health 2006, para 4.4, cited in: Wanless 2006).

In 2006 another commission, led by Sir Dereck Wanless, reviewed the social care sector and published the report *Securing Care for Older People*. Wanless found that the current system did not adequately respond to people's needs, that it was unfair towards people who possess a house or savings, and that at the same time the costs of the system would increase significantly in the coming years (Wanless 2006). This cost argument was particularly important in convincing the Treasury that something had to be done. The Treasury 'gave their blessing to the project' and commissioned the Department of Health to initiate a reform of the social care system (Interview Department of Health). It should be noted that the incentive to engage in a reform apparently stems from perceived problems with the existing programme. This is in line with expectation B4 regarding the feedback effect of existing social care system.

The reform plans started ambitiously by consulting a range of interest groups and 'ordinary' citizens (HM Government 2008). This 'Big Care Debate' resulted in a White Paper on social care being published. However, an actual reform had not yet been enacted by the time Brown lost the elections in 2010. Meanwhile, a programme ('Putting People First') had started to facilitate some smaller changes in the social care system. A grant of £520 million for three years was set aside to improve the quality of care (CSCI 2009: 8). The use of Personal Budgets and Direct Payments were especially encouraged. Brown also introduced a package of free home care for the elderly. After much criticism from opposition parties and serious amendments by the House of Lords, the package was passed just before the elections.[54]

Though initiated by the Labour government, both Conservatives and Liberal Democrats contributed to the 2010 White Paper on social care. There was a broad agreement that reform was necessary, but just not on how it was to be done. The main controversy concerned who should pay for social care. Social care became an important issue in the 2010 elections. After winning the elections, Cameron's government immediately set up yet another 'Commission on the Funding of Care and Support'[55]. What can be concluded, consequently, is that social care is continuously debated, but agreement on a reform track is apparently hard to reach.

[54] http://services.parliament.uk/bills/2009-10/personalcareathome.html
[55] http://carecommission.dh.gov.uk/.

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In the interim period, issues relating to the workforce have been an important concern for the Department of Health because of the difficulty associated with recruiting and retaining a skilled workforce – especially in the private sector. A representative of the National Care Association even suggested that the issue of migration has raised the awareness of problems in the social care sector:

> *I think it has brought the care sector in, the importance of the care sector as an employer and as an industry, it's brought it up the government agenda a little bit. After all there's between one and one and a half million workers, so it is an important employment area (Interview NCA).*

Indeed the government has taken several initiatives to address this problem, including, for example, the 'Care First Careers' programme, a joint programme of the Department of Health and the Department of Work and Pensions that gives employers financial incentives for recruiting young people into the social care workforce[56]. Several reports are produced discussing strategies for the recruitment and retention of skilled labour (see e.g. Department of Health 2007; Department of Health 2009).

However, in section 4.3 it was found that a fundamental reason for the difficulty in finding native employees willing to work in the social sector is the long hours of work required, the large number of (night) shifts, and the low pay. The only way to address these issues would be by substantially increasing public funding. Such steps have not been taken. In addition, there seems to be an inherent tension between a push towards a more personalised care system in which personal budgets and direct payments are central on the one hand, and the need to improve employment conditions in the social care sector on the other hand. This tension is not taken into account by policy makers in the Department of Health. Both trade unions and employers' organisations are worried that direct payments will fragment the workforce and lead to the isolation of employees (Interviews with UNISON and the NCA), but their concerns do not keep the government from encouraging direct payments.

4.5 Conclusion

Migrant workers are important in formal agency-based elderly care, but not in agency-based childcare. Families regularly employ a migrant worker as a childminder or as a nanny, but less often as an elderly carer. Irregular employment occurs, but there is no evidence that this is a very important phenomenon, at least not when compared to the Italian situation.

The demand for migrant care workers in the agency-based elderly care sector is a consequence of the job characteristics in the sector. Low pay, long working hours and a lot of

[56] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/workforce/DH_109986.

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shift work make it difficult to attract sufficient native workers. Although the sector is largely publicly funded, this funding is insufficient to improve employment conditions. The private employment of migrant care workers in childcare is induced by a combination of factors. While public services are targeted only at low and middle income families, those with a higher income often prefer a 'mother substitute' type of care.

Policy developments related to the employment of migrant care workers have been ambivalent. In childcare, there were no direct policy responses. There is more to be said about elderly care. The Department of Health has given different signals regarding the desirability of attracting migrant labour. Meanwhile, eligibility criteria for work permits for 'senior care workers' have been tightened. The wage requirement makes these permits unattractive for employers in the social care sector. This could have repercussions for the sector and it is unclear how these repercussions will be addressed.

The explanations for and policy responses to the employment of migrant care workers will be further assessed in a comparative perspective in chapter 6 and 7, but first chapter 5 will discuss the Dutch case study.

5 THE NETHERLANDS: THE STATE SHAPING THE SOCIAL CARE SECTOR

In the Netherlands, the employment of migrant workers in social care is limited. In agency-based employment, immigrants are underrepresented in the care sector in comparison with their share of the total labour force. There are some more migrant workers employed in agency-based elderly care in the bigger cities, but their numbers are lower than in the United Kingdom. An important phenomenon is the employment of migrant workers by households to do cleaning and related household tasks on an hourly base. This type of employment is mostly undeclared and often involves irregular immigrants. It is therefore difficult to find evidence of the numbers of migrants employed and on the exact work they do. As will be discussed in detail below, privately employed migrants sometimes provide childcare services, but private care for the elderly is scarce.

After discussing the evidence available on the employment of migrant care workers, the chapter continues with exploring the reasons why migrant care workers are so scarce. It is argued that the active role of social partners and the government in setting acceptable employment conditions and in recruiting and training new staff contributes to the limited demand for migrant workers in agency based care. At the same time, the extensive provision of agency-based elderly care services and the recently expanded publicly financed childcare sector both seem to crowd out the demand for private care. However, a variety of recent developments might change this situation in the near future.

The chapter ends with a discussion of the policy developments related to migrant care work. Direct policy responses, as far as they exist, have been mostly negative. The attraction of migrant workers is not considered as an appropriate solution for filling staff shortages. Therefore, it is rarely possible for migrant care workers to enter the Netherlands legally. In Dutch immigration policies no exceptions are made for this specific group of workers. Meanwhile, social care – both for children and for the elderly – has been expanded significantly during the 1990s. Large public investments have gone into the recruitment and training of new staff. These policies, however, came at a high cost. Therefore, recent governments have made several attempts to cut expenditure on social care. It will be suggested that these cuts might unintentionally encourage immigration into caring occupations.

Before continuing, let us have a short look at the existing research on migrant care work in the Netherlands. Some attention has gone to the employment of qualified migrant nurses and the policies that facilitated this employment (De Lange and Pool 2004; Roosblad 2005). The measures taken to attract these migrant nurses in the late 1990s and early 2000s are quite well

documented, but there is less information on what happened after that. Other research has considered the role of migrant domestic workers. The Commission for Filipino Migrant Workers published a report based on a survey of their own members working in the Netherlands (CFMW 2006). Botman (2010) studied the employment of migrant domestic workers in Amsterdam. Research on irregular migrants in the Netherlands has provided evidence of the existence of domestic workers (Engbersen et al. 2002; Van der Leun and Kloosterman 2006) and Van Walsum has studied the legal context within which migrant domestic workers are employed (Van Walsum 2007). Finally, some attention has gone to au pairs and their alleged abuse (ITS 2003). Unfortunately, none of these studies draw a nationwide picture of the importance of migrant domestic workers, and of the extent to which they engage in caring activities.

To supplement the limited information available from previous research, 13 interviews were carried out with representatives of interest organisations, policy makers and experts in the field. The interviews were carried out in Dutch and the quotes in this chapter were translated by the author. In addition, information was derived from diverse sources, ranging from publications by branch organisations to survey data and government responses to parliamentary questions. Moreover, five telephone interviews were conducted with randomly selected long-term care providers in Amsterdam. Compared to the previous two chapters, the Dutch study often has had to rely more often has to rely on qualitative evidence and on the impressions of involved actors. Fortunately, there is a considerable consistency in what all these different sources suggest, which makes it likely that the results are sufficiently reliable.

The structure of this chapter corresponds with that of the previous two. It starts with a description of the context of the Dutch welfare state, the labour market, developments in social care and a short history of immigration. Section 5.2 then proceeds to demonstrate the importance of migrant care workers in the Netherlands and section 5.3 attempts to explain the (limited) importance of migrant care workers. Section 5.4, finally, explores direct and indirect policy responses to the employment, or the absence, of migrant care workers.

5.1 Care and migration in the Netherlands

The Dutch welfare state and employment patterns

Scholars have had difficulties understanding the Dutch welfare regime. In terms of benefits the Dutch welfare state used to be one of the most generous and comprehensive in the world. Although public social spending as a percentage of GDP has decreased in recent decades,

inequality and poverty are still relatively low. The foundations for this generous welfare state were laid by a series of conservative Christian democratic governments in the post-war decades. Most benefits were dependent on previously earned wages, with the important exception of a universal old age pension (Becker 2000: 226).

The Dutch welfare state was built upon a gendered division of labour. Social policies were based on the idea that the appropriate role of women was within the private sphere. Women's labour market participation was strongly discouraged. As table 1.2 showed, in 1970 only 30 percent of Dutch women were employed, a rate among the lowest in Europe. The state was supposed to play only a subsidiary role vis-à-vis the family. Nevertheless, mandatory insurance for long-term care was introduced as far back as 1968 and has been expanded gradually in the following decades. Contrastingly, until the 1990s public childcare provision was virtually inexistent and 'the absence of [such] facilities as an alternative for caring in the family are understood [as] an important blessing for the welfare state' (Bussemaker and Van Kersbergen 1994: 23).

The sections below describe these differential developments in child and elderly care in the Netherlands. But before turning to that subject, let us first discuss the Dutch labour market. Employees in the Netherlands are well protected. Firing an employee without having a good reason is difficult and costly. Although eligibility criteria and generosity of social insurances have recently been tightened, ill, disabled or unemployed people can still count on benefits amounting to approximately 70 percent of their former wages.

Until the 1980s, employment rates, especially of women, were very low. Increasing this participation rate became a central objective of consecutive governments in the 1980s and 1990s. In the 1982 Wassenaar agreement, the use of part-time jobs was promoted to redistribute employment (Visser and Hemerijck 1997). In the years that followed, social insurance benefits were cut and eligibility criteria for benefits were tightened. All these measures were intended to promote labour market participation.

In the 1990s the employment rate of women grew substantially, to 59 percent in 1998 (see table 1.2). Part-time work was encouraged as a strategy for combining work and care. Between 1993 and 2001 the so-called 'combination scenario' (Knijn 2008) was promoted. The idea was (and still is) that both parents should work 32 hours, while both take responsibility for caring obligations. Parental or family care is then supplemented by some formal care services (Knijn 2008: 162). In contrast to many other European countries, part-time jobs are usually well protected. Employees have the legal right to work part-time, while being covered by the same social insurances and employment protection as those working full-time. As a consequence, part-time jobs are considered to be 'normal' and often 'good' jobs (Kremer 2001). Although the

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share of men working part-time is relatively high in the Netherlands, Dutch women are the absolute part-time champions. While the employment rate of women had increased to 70 percent in 2008 (the third highest in Europe, see table 1.2), 60 percent of these women worked part-time.

Elderly care

To understand the current organisation of Dutch elderly care, it is useful to have a look at its historical development. In the Netherlands, care facilities for older people provided by non-relatives have existed for centuries (Bijsterveld 1995: 161). While the well-off relied on servants or private homes, the less well-off had to turn to poor homes or old people's homes run by churches and local authorities (WRR 1988: 14). After World War II, the number of people living in old people's homes increased strongly, from 3.8 percent of all those aged over 65 in 1950, to 8.9 percent in 1975 (Bijsterveld 1995: 208). Gradually, old people's homes became a place for all older people, not just the poor. Initially, old people's homes were mostly alternative living arrangements, which did not provide many care services (WRR 2006: 116).

While the homes continued to be run primarily by voluntary organisations linked to the different Catholic, Protestant and secular pillars[57], public subsidies increased. It has been argued that the rapid expansion of old people's homes was a strategic reaction to the great housing shortages after World War II (WRR 1988: 14; Kremer 2000: 34; WRR 2006: 116). Though this might have played a role, there was also a political commitment to providing 'socially acceptable housing for the elderly' (Tweede Kamer 1954: 13). Moreover, the 1965 Social Assistance Act included a special provision on the use of social assistance payments to pay for the costs of a care or nursing home[58]. In 1968, a long-term care insurance (the AWBZ, Algemene Wet Bijzondere Ziektekosten) was introduced. It was a universal social insurance scheme covering the costs of nursing homes and long stays in hospitals, but excluding care homes and home care. This social insurance was financed through a mandatory insurance contribution supplemented by tax revenues. All the developments described above led to a gradual change of the position of the state from 'reserve role to central position'. 'Fairly silently the responsibility for the general provision of services and their quality became an element of public policy' (WRR 1988: 13).

[57] Until the late 1960s Dutch society was 'pillarized' into Catholic, Protestant and secular (subdivided into proletarian socialist and middle-class liberal) pillars or segments with organizational networks of their own (Becker 2000: 222).

[58] People became eligible for such payments based on an individual needs test and irrespective of their family's income or capacity to care (Algemene Bijstandswet, Art. 8).

In the 1970s it was increasingly recognised that home care services could provide a cheap alternative for expensive long-term care institutions such as nursing and old people's homes. Therefore, investments were made available for these type of services (Tweede Kamer 1970; Tweede Kamer 1975). At the same time, to suppress the rising costs of home care services, initiatives were taken to recruit housewives into the job. In 1977 the 'alpha helper' category was introduced (Tweede Kamer, zitting 1976-1977, 14396, nr. 1). This category still exists and has recently sparked controversy, as will be discussed at the end of this chapter. An 'alpha helper' who enters into a direct contract with her client is, under certain conditions, exempted from paying taxes and social insurance premiums. Moreover, the alpha helper lacks many forms of protection, including minimum wages, unemployment and illness insurance benefits.

While consecutive governments tried to contain the costs of elderly care services, the long-term care insurance (AWBZ) was gradually expanded. By 2001 this insurance included home help and home care services, and residence in care homes. In the mean time, the push towards home care services as an alternative for living in a residential care home had become effective. In the 1990s the number of residents in residential homes decreased. However, home help and home care services had not expanded sufficiently in response to increasing needs for extramural services. As a consequence, long waiting lists emerged. At that point the government decided to change its course and strongly increased investments in long-term care. As can be seen in table 5.1, the volume of home help and home care provided increased substantially from 17.2 percent in 1999 to 20.1 percent in 2005. Nursing homes remained available for a about 2.5 percent of all older people, while the number of people aged over 65 in residential homes decreased from 4.9 percent to 4.3 percent[59]. The Dutch figures for institutional care fit well with the OECD data presented in table 1.5, which showed a total of 6.9 percent of all elderly in institutional care. However, the home care coverage rate in the Dutch data (20.1 percent) is much higher than the 13.1 percent in the OECD data. The reason for this discrepancy is that the Dutch data in table 5.1 include home help services (such as cleaning) which the OECD does not consider to be part of long-term care.

[59] The decrease in residential home coverage reflects an actual decrease of the number of people in residential homes, from 106,282 in 1999 to 98,809 in 2004. On the contrary, the number of people in nursing homes increased in absolute numbers from 51,458 in 1999 to 56,115 in 2004.

Table 5.1: Percentage of age category receiving home help or care services financed through the AWBZ, and percentage living in residential and nursing homes

Age category	Receiving home help or care		In nursing homes		In residential care homes	
	1999	2005	1999	2004	1999	2004
65-69 years	5,4	5,8	0,4	0,4	0,3	0,2
70-74 years	11,2	12,1	0,9	1,0	1,0	0,8
75-79 years	20,8	23,8	2,2	2,2	3,0	2,5
80-84 years	32,4	37,9	4,6	4,5	9,3	7,5
85-89 years	38,7	46,1	8,0	7,9	21,1	18,3
90-94 years	36,6	44,4	12,3	11,5	36,8	32,3
95+	31,1	36,2	15,7	15,0	48,9	45,8
Total	17,2	20,1	2,4	2,5	4,9	4,3

Source: Nursing and residential care homes, CBS (2006: 104); home help and home care, CBS (2007), own calculations.

In the 1990s, a Personal Budget (Persoonsgebonden budget) was introduced. Instead of relying on in-kind services, an AWBZ recipient could choose to receive a cash benefit, which recipients could spend on whatever services they so wish. The Personal Budget was gradually expanded in subsequent years. One of the options included in the Personal Budget is to engage a family member. The expenses always have to be accounted for, so the client has to keep a record of how much is spent on each service and they have to record details of who provided the service. In 2006, 9.5 percent of all recipients of AWBZ-financed care opted for a Personal Budget (Ramakers et al. 2007: 5).

Currently, all Dutch citizens are insured and can rely on the AWBZ when they are in need of long-term care. Clients can be charged fees depending on their income, but these fees never amount to the actual cost of the service. As a consequence, it is normally cheaper to rely on publicly organised services than to opt for a private solution, regardless of your income. There are, nevertheless, some private care homes, but there are no data available on the exact numbers. People living in private care homes can still apply for AWBZ funding for specific care services.

In 2007 an important reform of the AWBZ took place. Home help services were taken out of the AWBZ and became part of the new Social Support Act (WMO, Wet Maatschappelijke Ondersteuning). Under the new WMO the responsibility for the provision of home help services was decentralised to local governments. People no longer have the right to

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receive domestic help. Instead, local governments have the obligation to provide appropriate support. The WMO has increased marketisation and competition in the home care sector, because local governments have to organise (a public process in which different private providers compete, trying to get the responsibility for service provision) according to European competition regulations. In the first round of tenders many providers offered services below their cost price. As a result, they had to try to cut these costs, which many organisations did by forcing their employees to start working as independent (and cheap) alpha helpers. The alpha helper, as was described above, enters into a direct contract with her client and is exempted from certain social protection. At present alpha helpers are allowed to work for a maximum of three days a week without paying social security contributions, while their employer is exempted from paying taxes and social security contributions. Some 65,000 people worked as alpha helpers in 2008 (ZIP 2009: 17).

Childcare

In the post-war decades, the ideal model of mothers taking care of their own children in a family environment was widely shared by political parties from all different orientations (Bussemaker 1998: 71). The first Dutch day care centres (called 'kinderdagverblijven') provided care for children of lower class parents. They were financed through charity, some public funding from social assistance (the 'Armenwet') and parental contributions (Zwier 1989: 14-18). In the 1960s, due to labour shortages, some companies provided childcare facilities. Yet this remained an exception and was even kept hidden since it went against public opinion at the time (Tijdens and Houweling 1993: 35). After the first oil crisis in 1973, companies' childcare centres disappeared quickly. The only childcare provisions that were developed in the 1970s were playgroups for toddlers. These were initiated by parents but became part of government policy soon after. Playgroups can be attended only a few hours per day. They aimed to give mothers some time off and at the same time to contribute to children's development.

In the 1970s and 1980s, the need for childcare services was increasingly linked to women's emancipation and autonomy. However, in the still conservative political environment dominated by Christian Democratic parties, these claims were rarely successful. Finally, a turnaround occurred in the late 1980s. At that time, childcare was increasingly seen as an instrument of labour market policy that could be useful for increasing women's employment rate (Bussemaker 1998: 87). In 1990, a temporary stimulation measure for childcare ('Stimuleringsmaatregel kinderopvang') was introduced and funds were made available for childcare expansion. Municipalities were responsible for setting up and subsidizing day care centres, while companies were stimulated – through subsidies and tax relief – to provide

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childcare for their employees (Gustafsson 1994: 56). The stimulation measure became a success. It was extended several times and led to a very large increase in the number of children attending day care centres, from 5.7 percent of all children between 0 and 3 years old in 1990 to 25.9 percent in 2006. The numbers presented in table 1.5 in the introduction are even higher, because these include children attending playgroups, which are still popular. Table 1.5 also shows that almost all children attend childcare on a part-time base. Day care centres are usually attended for 2 to 4 days a week. On the other days the child is cared for by a parent (usually the part-time working mother) or a grandparent.

Table 5.2: Percentage of children aged 0-3 using formal day care provided in day care centres and by guest parents

	1990	1996	2000	2004	2006
Day care centres	5,7	13,1	20,2	24,9	25,9
Guest parents	0,1	0,7	0,9	0,9	1,4

Source: SCP (2009: 131-2)

In 2005 a new childcare law was enacted. It radically reformed the Dutch childcare system. Subsidies were no longer provided by local governments to day care centres, but were transferred directly to the parents. Parents can choose what kind of care they want to purchase for their child. They can opt for a day care centre, but also for a guest parent, who takes care of one or several children either in the guest parent's home, or at the children's home. Initially, employers were expected to contribute to the costs of childcare on a voluntary base, but in 2007 employers' contributions became mandatory, payable through a tax levy. In the same year state subsidies were also increased meaning that parents on average had to pay for only 19 percent of real childcare costs. The additional 81 percent of costs was refunded by the state. The actual amount of the costs parents can get refunded depends on their income, but even high-income families can count on a substantial subsidy (33 percent of the costs of childcare for the first child and 90 percent of the costs for the second). As a consequence of the new arrangements, the number of children in day care centres increased from 250,000 to almost 300,000 in just one year (CBS 2008). Even more explosive was the growth of the use of registered 'guest parents', which were eligible for the same amount of funding as day care centres, making them an attractive alternative for many parents.

Although policy changes have made childcare much more accessible, there are concerns about the quality of provision. By leaving the provision of childcare services entirely to the market, it has become more difficult for the government to control the quality of these services. Knijn cites evaluation figures suggesting that the quality has deteriorated (Knijn 2008: 168).

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This has become an issue of concern for policy makers – an issue to which I will return later in this chapter.

Immigration

Immigration to the Netherlands has been shaped by the country's colonial history and by foreign labour recruitment during the 1960s. When Indonesia became an independent state in 1949, there was already a strong inflow of Indonesians, despite the government's efforts to discourage it (Muus 2004: 263, 266-7). In the late 1950s and the 1960s Dutch industries started to recruit foreign labour from countries around the Mediterranean. Special agreements on recruitment were concluded with Mediterranean governments (Italy, Spain, Portugal, Turkey, Greece, Morocco, Yugoslavia and Tunisia) (Muus 2004: 264). Although there never was a formal halt to these recruitment processes, they effectively ended in 1973, after the first oil crisis. By that time, approximately 200,000 young male labour migrants had come to the Netherlands (Van Tubergen and Maas 2006: 7).

While return rates of the guestworkers were still high prior to 1973, the end of recruitment changed this pattern. Many migrants, especially from Turkey and Morocco, decided to settle and opt for family reunification in the Netherlands. As a consequence, the Turkish population in the Netherlands grew from 53,500 Turkish nationals in 1974, to 308,000 persons who were born in or had at least a parent born in Turkey in 2000. For Moroccans these figures were 29,600 in 1974 and 262,000 in 2000 (Muus 2004: 268-9).

Another colony-related influx of migrants came from Surinam, which became independent in 1975. Independence was expected to halt the tide of emigration to the Netherlands, but the opposite happened. Many Surinamese moved to the Netherlands because of the political uncertainty in their home country, which was caused by the independence. Large inflows continued until 1980 when stronger visa requirements became effective. By 2000 it was estimated that around 300,000 persons born in Surinam or with at least one parent born in Surinam lived in the Netherlands (Muus 2004: 267-8). When the economic situation on the Netherlands Antilles – still part of the Kingdom of the Netherlands – deteriorated in the 1990s, migration to the Netherlands increased. In 2000 it was estimated that 107,000 persons in the Netherlands were born or had a parent born in the Antilles.

There are now four main routes of immigration into the Netherlands. The first is through family reunification, which is possible under specific circumstances (settlement permits and adequate income and housing). The Dutch government has increased its efforts to restrict marriages by verifying whether they are 'genuine'. In 2007 a new Civic Integration Act came

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into effect. Since then, immigrants wishing to settle in the Netherlands, including for reasons of family reunification, have to pass a civic integration examination relating to their knowledge of the Dutch language and the Dutch society. They can complete this test in their country of origin prior to departing for the Netherlands or in the Netherlands if they already reside there (Bruquetas-Callejo et al. 2007: 9). Regardless of these restrictions, family migration is still one of the most important forms of permanent migration (OECD 2008a: 265).

A second important route for entering the Netherlands is through asylum applications. The number of asylum seekers increased in the late 1980s. Simultaneously, it became a public issue. In 1987 a Regulation on the Reception of Asylum seekers (ROA) was passed, with the aim of limiting the attractiveness of the Netherlands as a country of destination for asylum seekers (Muus 2004: 274). This aim has not been very successful since the number of asylum requests increased from 21,208 in 1990 to 52,576 in 1994 (a record due to the war in the former Yugoslavia). In the following years it fluctuated and in 2000 a total of 43,890 applications were filed. However, only a fraction of these applications were actually granted refugee status (Muus 2004: 275). In 1998, and again in 2002, the procedure for asylum application was changed and obtaining a refugee status became even more difficult (Entzinger and Fermin 2006: 38). The policy changes seem to have been effective, as the number of asylum applications decreased to 9,800 in 2004 (and back to 14,500 in 2006) (OECD 2008a: 264). In 2007 a "general pardon" was enacted, allowing asylum seekers who were in the Netherlands already before 2001 and had lived in the country without interruptions to regularise their status.

A third way to obtain a residence permit in the Netherlands is through labour migration. From 1968 'all foreign workers were supposed to pass through formal recruitment channels, and any "spontaneous" labour migrant had to obtain a work and residence permit before arrival.' (Muus 2004: 278). In 1995, a new Law on the Employment of Foreigners (Wet Arbeid Vreemdelingen, WAV) was enacted. It allows the granting of temporary work permits only for publicly announced vacancies for which no native worker could be found. The number of work permits issued rose from 9,500 in 1996 to 27,700 in 2000, mostly for intra-firm transferees and highly skilled specialists (Muus 2004: 269-70). In 2006, 74,000 temporary work permits were issued, of which 75% were for Polish nationals (OECD 2008a: 264). In addition to immigration via the WAV, special covenants have been agreed on by the social partners for specific sectors. 'These tripartite agreements permitted workers in particular economic sectors to be temporarily admitted to the country, while anticipating the availability of newly trained qualified Dutch workers' (Bruquetas-Callejo et al. 2007: 6). An example is the 2000 covenant on foreign nurses (De Lange and Pool 2004).

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In 2007, the Dutch government lifted restrictions on citizens from the Eastern European countries that had entered the European Union in 2004 (the A8). From then on, these citizens could work in the Netherlands without any restrictions. By 2008, free movement was numerically the most important way in which foreigners obtained access to the Netherlands (see Appendix table A-3). Estimates suggest that at least 100,000 Eastern Europeans had come to work in the Netherlands by the summer of 2007 (Regioplan 2007: 35).

Finally, in the 1990s, regulations and controls on undocumented immigrants became stricter. A one-off regularisation measure was enacted in 1997 for people who had been in the Netherlands without a valid permit for at least 6 years without interruption. The 1998 Linkage Law (Koppelingswet) allowed for the linkage of immigration registration files, census bureau files, and documents from the fiscal identification agency and social services, in order to verify the validity of foreigners' residence and work status as well as to prevent irregular migrants from receiving any social security or other welfare rights (Muus 2004: 279). In 2005 it became easier to fine employers who employ irregular immigrants and fines also increased[60].

5.2 The limited importance of migrant workers in social care

Migrant workers in agency based employment

The Dutch statistical bureau defines as 'allochthonous' those people of whom at least one parent was born abroad. This definition is so broad that even the Dutch queen and the crown prince are allochthonous. Unfortunately, all available indicators related to the employment of migrant workers in the social care sector apply this definition.

Between 1999 and 2004, the percentage of migrant ('allochthonous') workers employed in the social care sector grew by approximately 1 percent, which is similar to the growth in the total migrant working population (Prismant 2007: 26). Table 5.3 shows the employment of migrant workers in social care in 2004. At the time of writing no more recent detailed figures were available. However, a recent survey of employees in caring occupations, carried out by Prismant in 2009, found a similar total for allochthonous workers as emerged from the 2004 survey (Smeets et al. 2010: 14). Therefore, there is no reason to assume that the number of migrant workers in caring occupations has substantially increased since 2004.

In comparison with the total labour force, migrant workers are underrepresented in all social care sectors. While 17.7 percent of the total workforce is 'allochthonous', this percentage is only 13.5 in residential and nursing homes, 11.3 in home care, and 15.1 in childcare. Only

[60] Tweede Kamer, vergaderjaar 2007–2008, 19 637, nr. 1207.

Surinamese and Antillean workers are overrepresented in residential care and childcare. Of all employees in the residential care sector, 3.1 percent were Surinamese and 1.0 Antillean, compared to 2.8 and 1.2 percent respectively in childcare and 2.1 and 0.7 in the total labour force. Surinam is a former Dutch colony and the Netherlands Antilles still form part of the Kingdom of the Netherlands. Many people from these regions arrived in the Netherlands in the 1970s or before. Therefore, it is impossible to say whether the percentages reported here consist of migrants who arrived in the Netherlands recently or people who have lived in the Netherlands all of their life. Migrant workers from both 'other western' countries – including all European countries – and 'other non-western' countries are substantially underrepresented in the social care sector.

Table 5.3: Migrant[1] employees in social care as percentage of all workers in the sector, 2004

Country/region of origin	Residential and nursing homes	Home care	Childcare	Total labour force
Total allochtonous	13.5	11.3	15.1	17.7
Morocco	0.8	0.5	1.3	1.0
Turkey	0.5	0.3	1.0	1.5
Surinam	3.1	2.2	2.8	2.1
Netherlands Antilles and Aruba	1.0	0.6	1.2	0.7
Other not-western countries[2]	1.6	1.1	1.7	2.3
Other western countries[3]	6.4	6.6	7.2	9.0

[1] Migrant here defined as 'allochthonous', i.e. having a foreign born father or mother.
[2] Including: Turkey, all other countries in Africa, Latin-America and Asia except for Japan and Indonesia.
[3] Including: all European countries except Turkey, North-America, Oceania, Japan, Indonesia.
Source: Prismant (2007: 27, 31)

A more recent study of the number of allochthonous workers in nursing and care homes in Amsterdam and the surrounding region was carried out in 2006. It was found that 29 percent of the employees of the surveyed nursing and care homes were allochthonous (SIGRA 2008: 4). This was an increase of 4 percent compared to 2002 and an overrepresentation compared to the total percentage of migrants working in Amsterdam and surroundings (ibid.: 6). The great majority of the employed allochthonous workers were Surinamese (54 percent), 10 percent were Moroccan, and 21 percent came from elsewhere (SIGRA 2008: 8). Allochthonous employees were slightly overrepresented in the low qualified 'assisting' and 'helping' occupations (ibid.: 10). In 2006, almost one in four new employees was allochthonous (ibid.: 13).

The figures for Amsterdam suggest that the situation in bigger cities differs from the nationwide importance of migrant workers. However, most of the allochtonous employees in

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Amsterdam are Surinamese and therefore likely to be second generation immigrants, who are not the subject of this research project. Indeed, the phone interviews with care providers in Amsterdam suggested that a large part of migrants are from Surinam or have Antillean origins and were born in the Netherlands or have lived there for a very long time. But there are also more recent immigrants. Among the countries of origin that were mentioned are Ghana, Ethiopia, Eritrea, Brazil, British Guinea, Mongolia, and Bulgaria. Most of them came to the Netherlands as refugees or through family reunification. There are some workers from Eastern Europe, but not many. For people who recently arrived in the Netherlands, large care providers organise language classes and other types of training. Several organisations reported to have actively recruited foreign workers. One attracted Indonesian and Polish workers, another one had a project involving nurses from the Philippines. Both organisations reported that these attempts were not very successful.

Let us have a last look at migrant workers from Eastern European countries that joined the EU in 2004 (the A8). Eastern Europeans were mostly employed in agriculture, in construction and in other industries. Social care was not among the top 15 jobs for which work permits were granted between 2004 and the summer of 2007 (Regioplan 2007: 29). In 2007, labour market restrictions for A8 citizens were lifted. As a consequence, it is difficult to tell how many workers from these countries entered the Netherlands after that, and in which sector they have started to work. There is no evidence that the inflow of Eastern European workers has affected the social care sector. On the contrary, according to a civil servant responsible for immigration policy, Eastern Europeans 'work everywhere but in the care sector' (Interview Ministry of Justice). Another civil servant confirms this picture: 'I think there are very few labour migrants from inside the EU, in general very few labour migrants in the care sector' (Interview Ministry of Social Affairs and Employment – 2).

A final question is whether there are many irregular migrants employed informally by care providers. There are no indications that this is the case. Labour inspectors do not consider the care sector to be a sector 'at risk' of employing irregular immigrants, and do not report any such cases (Arbeidsinspectie 2009: 54). In response to a question about whether other organisations in the sector would employ irregular immigrants, a Dutch care provider answered: 'I don't think so, we are not a horticultural business. I think most organisations in the sector are adhering to the rules' (phone interview care provider).

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Migrant workers in private care

Local studies in the largest Dutch cities suggest that many (undocumented) migrant workers are employed as domestic workers, usually as cleaners for several hours per week (Botman 2010). Van der Leun and Kloosterman (2006) conducted interviews with undocumented migrants in Rotterdam. They found that, compared to earlier studies, these undocumented immigrants increasingly worked for private households:

> *[T]he follow-up study reveals especially that respondents from the former Soviet Union, Iran and Sri Lanka have found their way to Dutch families. They work as baby sitters, house cleaners and odd-jobbers and Dutch dual income households profit from their services and their reasonable prices (Van der Leun and Kloosterman 2006: 66).*

The problem is that all this happens in the private domain. There is hardly any form of detection and therefore information is scarce (Van der Leun and Vervoorn 2006: 6). Nevertheless, many sources confirm the increasing importance of migrant domestic workers in larger Dutch cities. A 2007 report on labour migration by the Socio-Economic Council states: 'it is known that migrant workers (especially female) from developing countries are employed in personal services in the Netherlands' (SER 2007: 171, author's translation). Van der Leun and Vervoorn write that 'from Dutch studies it becomes clear in any case that migrants, among whom probably many are illegally present, increasingly find their way to private households' (Van der Leun and Vervoorn 2006: 6, author's translation). In her research on domestic workers in Amsterdam, Botman (2010) found that these were mostly foreign workers and very often irregular.

The best organised and most well-known group of migrant domestic workers consists of Filipinos, but the nationalities working in domestic services seem to be highly diverse, including many different countries in Asia, Africa and South-America (CFMW 2006). This is again confirmed in the interviews with concerned actors (Interviews Transnational Institute, AbvaKabo, RESPECT, Botman). Eastern Europeans represent a special category and an increasingly important group (Interview Transnational Institute). They often come in couples: the man works in construction, the woman works as a cleaner (Interview Botman).

What do these domestic workers do? Based on Dutch police data on apprehended undocumented immigrants, Leerkes et al. found that domestic workers hardly ever lived with their employers (Leerkes et al. 2007: 1512). Similarly, regarding live-in domestic work Van der Leun and Vervoorn conclude that 'in the Netherlands this is rather unusual […]. Illegal respondents who work in households usually do this on an hourly base, just as the traditional autochthonous cleaning lady or baby sitter' (Enbersen et al. 2002 in Van der Leun and Vervoorn 2006: 6, author's translation). In the interviews with involved actors the same conclusion is

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drawn: 'The core business is cleaning and domestic work' (Interview AbvaKabo). But, it is mentioned that caring tasks are also – increasingly – included: 'they do care for children. Caring for the elderly maybe not' (Interview Transnational Institute).

It is, again, difficult to find quantitative evidence for the claim that migrants are important as private child carers. A 2003 E-Quality report indicated that some Dutch (working) parents would hire an au pair or an undocumented migrant domestic worker to care for the children (Kohlman 2003: 37), but the author gave no evidence for this development.

Table 5.4 below shows the number of approved au pair requests. Officially an au pair is not considered to be an employee. He or she is not allowed to work for more than 30 hours per week. In practice, however, au pairs have been found to work as ordinary employees. Therefore, it is worth considering the quantity of migrants who came to the Netherlands to care for children under the au pair scheme. In the official data a distinction is made between those who do not have to apply for authorisation for a temporary stay (an MVV) – these include EU – citizens and people from Australia, New-Zealand, Canada, the US, South-Korea and Japan – and on the other hand those – all other nationalities – who do have to apply for an MVV. Many more permits were issued to the groups that had to apply for an MVV-authorisation, hence to citizens of non-western countries (see table 5.4). Within this group the numbers of permits granted increased from 242 in 2004 to 920 in 2007[61]. Unfortunately, a further breakdown of nationalities is not available.

Table 5.4: Granted residence permits for au pairs, 2004 – 2007

	2004	2005	2006	2007
Au pair residence permit with 'authorisation for temporary stay' (MVV) [1]	242	527	657	920
Au pair residence permit without 'authorisation for temporary stay' (MVV) [2]	18	16	63	45

Source: figures provided by the Ministry of Justice.
[1] No 'authorisation for temporary stay' (MVV) is required for EU and EEA citizens, as well people from Australia, New Zealand, Canada, the United States, South-Korea and Japan. All other nationalities need to apply for an 'authorisation for temporary stay' in addition to applying for a residence permit.
[2] Since spring 2007 A8 citizens do not need to apply for a residence permit anymore.

The very small number of au pair permits issued to those who do not have to apply for an MVV – i.e. EU citizens and some selected nationalities – suggests that there were hardly any au pairs

[61] A report on au pairs in the Netherlands (ITS 2003) suggests that 1,465 applications for an au pair permit were filed in 1999, 1,314 in 2000, 1,168 in 2001 and 1,560 in 2002. It is unclear how many of those applications were actually granted a work permit, but these figures suggest that 2004 formed an all-time low.

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from Eastern Europe entering the country in these years. Between 2004 and 2007 these au pairs still officially had to apply for a permit to work as an au pair, but as can be seen in the table, very few did. This is surprising given that a 2003 report on the situation of au pairs in the Netherlands still found many Eastern European au pairs. Of all those who had been granted a permit in the first half of 2002, 47 percent came from Eastern Europe, followed by Africa (30 percent) and Asia (19 percent) (ITS 2003: 18).

A representative of the Dutch Au Pair Organisation (NAPO) confirmed that au pairs are becoming increasingly popular in the Netherlands. He noticed a shift in the country of origins of au pairs, which is in line with the data presented above. While until 2004 most au pairs came from Eastern Europe, after this year they increasingly came from Latin America, Southeast Asia and Southern Africa[62].

Whether the au pair category is indeed, as has been suggested, abused as a basis for households to have cheap labour (Interview Transnational Institute) is unclear. Van der Leun and Vervoort see no evidence for this claim (Van der Leun and Vervoorn 2006: 6). In any case, what can be concluded from the interviews is that (irregular) migrant workers are sometimes employed for childcare.

Hardly any evidence is found, however, for the employment of migrants as private elderly carers. The interviewees had no experience with migrant elderly carers, except for one, who knew a migrant living with an 85 year old woman in The Hague (Interview CFMW). Apart from this one example, there is no reason to believe that private elderly care has become an important occupation. Household survey data (*Aanvullend Voorzieningen Onderzoek, AVO*) show that there was no increase in the employment of private care workers between 1987 and 2003. Only between 0.0 and 0.1 percent of all respondents reported hiring a private care worker (own analysis AVO data). A closer look at the 2004 data shows that from the 14 respondents hiring a private carer, only 1 was over 65 years old. In addition, and contrary to the English case, there are hardly any agencies providing mediation services for the employment of private carers[63] and none that explicitly mention migrant workers.

In conclusion, evidence of the employment of migrant workers in social care in the Netherlands is sketchy. It is often based on indirect evidence and interviews with experts and interest group representatives. Nevertheless it seems safe to conclude that migrant workers have not played a large role in agency based work and private care. Despite this, there are two exceptions. First of all, migrant workers were somewhat overrepresented in formal agency-based care provision in Amsterdam. However, a large share of this so-called 'allochtonous'

[62] NRC-Next, 2-5-2007, Ambitieus achter de buggy. Au pairs in Nederland komen niet om te sloven, maar voor de ervaring.[???]
[63] But see http://www.levthuis.nl/page3.html .

workforce is probably made up of second generation immigrants. Second, (irregular) migrants are often employed as domestic workers on an hourly base, and there is some evidence suggesting that migrant workers are employed as au pairs or nannies.

Table 5.5: Types of employment of migrant workers in social care in the Netherlands

		Employer	
		Agency	**Household**
Employment relationship	**Formal**	*Childcare: low* *Elderly care: low*	*Childcare: low* *Elderly care: low*
	Informal	*Child and elderly care: unknown, but unlikely*	*Childcare: some* *Elderly care: low*

5.3 Explaining the limited importance of migrant workers

The number of migrant workers in both agency based and private social care in Netherlands is limited (see table 5.5). In comparison to the UK and Italy it is especially striking that migrant workers are infrequently employed in elderly care. Although there is some employment of migrant workers in the largest cities, there is no evidence of an overrepresentation of immigrants in this sector as occurred in the English situation. In addition, there is no evidence of migrants being employed privately to care for older family members, a phenomenon that is common in Italy. As in the UK and Italy, migrant workers are not frequently employed in agency based childcare, but there are some migrants working in private childcare, as au pairs or nannies.

Why are migrant care workers so scarce in the Netherlands? Explaining why a phenomenon is not taking place is difficult. Based on the single case study of the Netherlands, one can only propose tentative explanations based on theoretical expectations, contextual factors and interview material. In chapter 6 these explanations will be examined more rigorously from a comparative perspective. Below, it is first examined why migrants are so scarce in agency based employment in child and elderly care. The explanation focuses on employment conditions in the sector and on previous negative experiences with the employment of migrant nurses. Thereafter,

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it is discussed why migrants are also scarce in private care. It is argued that the need for private care is limited, while Dutch culture also seems to discourage the full-time private employment of migrant workers. Moreover, the control elements included in personal budgets and guest parent subsidies have prevented irregular employment.

No demand for migrant labour in agency-based care services

Expectation A1, discussed in chapter 2, suggested that migrant workers are overrepresented in sectors which are characterised by poor working conditions, such as long working days, irregular shifts, limited opportunities for promotion, and (possibly) low pay. The lack of migrant workers in the Dutch agency-based care sector could hence be related to the good working conditions in this sector. This section investigates whether this is indeed the case?

Pijl and Ramakers point out that, in the past decade, government, trade unions and employers have 'cooperated in pursuing an active personnel policy in the care sector' (Pijl and Ramakers 2007: 84). The state and social partners together have tried to offer good working conditions and salaries in times of labour market shortages, and they have attempted to safeguard jobs in times of recession (ibid.). Let us have a look at these elements in more detail.

In a survey of employees in the care sector, 64 percent of employees said they were satisfied with their employment conditions (ZIP 2009: 17). In long-term care (nursing homes, care homes and home care), 63 percent of the employees worked on Sundays, 53 percent worked late shifts and 19 percent worked night shifts (Smeets et al. 2010: 63). Nevertheless, most employees were satisfied with their working times. They especially appreciated the possibility of working part-time (ibid.: 58).

Employees are less satisfied with their wages. However, in 2004, employees in the care sector with a lower or average education earned on average three percent more than comparable employees in other sectors (ZIP 2009: 17). If one takes into consideration the fact that most employees in caring occupations are women and that women tend to earn less than men, then the higher average income suggests that women are relatively well paid in the care sector (Pijl and Ramakers 2007: 84). A third factor that might make the care sector attractive relates to the career options available to employees. In the care sector, skilled staff form a large proportion of the labour force compared to other countries. There is also a substantial mobility towards higher functions (Prismant 2009b). The care providers in Amsterdam who were interviewed for this research all reported that the recruitment and training of staff was a high priority. One important element is the internal training of employed staff. Finally, 90 percent of employees report that

they like their work (ZIP 2009: 17), but they also report that the job is physically and emotionally demanding.

So far it seems that the limited number of migrant workers in social care sector may be related to good employment conditions. Pay is sufficient, the possibility of working part-time is highly valued, there are opportunities for job mobility, and people in general like their jobs. The importance of working conditions will be further assessed in a comparative perspective in chapter 6.

Although the discussion so far has suggested that native workers have been sufficiently available and willing to work in the social care sector, there have been experiments with the attraction of foreign nurses. These experiments occurred primarily in the late 1990s, when the Dutch economy was doing well and labour shortages became a big problem in the care sector. Therefore, several hundreds of skilled nurses from South Africa, Poland, Indonesia and the Philippines were employed in the Dutch care sector.

The experience of these experiments has been 'all negative' (Interview Ministry of Justice). The Dutch Scientific Council for Government Policy (WRR) writes:

> *Until today, in the Netherlands all formal experiments have failed. It proves to be problematic to place nurses and carers from another cultural backgrounds in the Dutch care sector (WRR 2006: 129).*

The reasons given for this failure by the employers are often related to language.

> *This has everything to do with language skills, most migrants from Central and Eastern European countries speak very bad or hardly any Dutch. And that makes them less suitable for positions in personal care. People do not like to have persons […] at their bed whom they don't understand (Interview Ministry of Social Affairs and Employment – 2).*

In addition, there were cultural problems. According to a civil servant at the Ministry of Justice, 'People couldn't get used to this country', because of 'too big cultural differences':

> *Attitudes towards work are different from here. There you would do something when you got an assignment, and if you didn't get an assignment, than you would just do nothing. That's not how it works in the Netherlands (Interview Ministry of Justice).*

Dissatisfaction was also present amongst foreign employees. They were often highly educated and were consequently disappointed by the type of work they could do in the Netherlands (Roosblad 2005: 89). Skilled Polish nurses, for example, were eventually only employed as care assistants, because their qualifications were not recognised (De Lange and Pool 2004). In addition, wages were disappointing considering that rents had to be paid and the costs of living were high (Interview Ministry of Justice). In short, these projects were tried 'once but never again' (ibid.). In fact, these negative experiences have reinforced the efforts by the government

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and social partners to attract and maintain native workers in the sector, as will be further discussed in the last part of this chapter.

In conclusion, besides the relatively good working conditions in the social care sector, another reason for the low share of immigrants working in the sector might be the failure of previous experiments with attracting migrant nurses. This failure was largely attributed to language and cultural differences and led to a largely shared consensus that migrant work is not an ideal solution.

Private care and migrant labour

Similar to agency-based care, the employment of migrant workers in private personal care has been limited. While hardly any evidence was found for the employment of private elderly carers, there were indications of some immigrants employed as nannies or au pairs. Why is the private employment of migrant carers generally scarce, and why is it slightly more common in childcare than in elderly care?

In chapter 2 it was suggested that the provision of publicly financed agency-based care services could crowd out private migrant care work (expectation A4). In the Netherlands, it seems indeed that publicly financed care provision, in combination with the available family care, covered the needs of most elderly – at least until recently (SCP 2007a). While the percentage of elderly in residential care has remained more or less stable, the percentage of elderly receiving home care services has increased from 17.2 percent in 1999 to 20.1 percent in 2005 (see table 5.1). The coverage rates of both residential and home care services are among the highest, if not *the* highest, in Europe (see table 1.5). Moreover, contrary to the British situation, both low and high-income groups can benefit from the Dutch social care system. Although people who are better-off pay a relatively high out of pocket contribution, publicly organised care is usually still cheaper than private care.

The availability of childcare services has increased steeply in the past years. Childcare subsidies are available for all income groups. Their generosity depends on family income, ranging from one third to the total costs. The use of childcare services has also increased strongly in recent years (see table 5.2). Although many parents opt for formal services, there is still a wide use of informal care. This informal care is mostly provided by family or friends, and to a much lower degree by paid carers (SEOR 2004: 39).

There is another element that might contribute to the limited demand for private care. Most Dutch women work part-time. Mothers with young children, in particular, rarely have a full-time job (see OECD 2011a and figure 6.3 in chapter 6). Many people have flexible working

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hours and can make special arrangements with their employers. This facilitates the combination of employment with informal family care and decreases the need for full-time care services.

In addition to these needs based explanations there could be a cultural element at stake. The means-tested contributions payable in care homes amount to a maximum of €1800, which is still double the amount Italian families pay for a private carer. Therefore, why has a market for private carers not emerged in the Netherlands? In the bigger cities there is a large group of immigrants engaged in cleaning activities. In theory these could be engaged to care for elderly family members too, and yet they are not. One of the explanations might be the existence of 'cultural taboos on sharp class divisions' (Leerkes et al. 2007: 1512), which would inhibit the employment of a personal servant in general. Botman points out the Dutch Calvinist attitude of 'I can do it myself' (Interview Botman).

In addition, as was mentioned in the discussion of Dutch elderly care before, the Netherlands has a long tradition of reliance on non-familial forms of elderly care, from poor homes to home care provision. In relation to this, Dutch elderly often live independent from their children. Only 3 percent of Dutch elderly aged over 80 lived with or in the same building as a child, compared to 42 percent in Italy (see Appendix table A-1). Compared to Italy, very few Dutch people believe that long-term care should be provided or paid for by relatives (see Appendix table A-4). By contrast, in childcare a tradition of informal care is much more prevalent. Until recently, a taboo actually existed relating to the use of formal day care services. The ideal form of childcare was, and in many cases still is, mother's care (Kremer 2007). These different ideas about child and elderly care may explain why private care by migrant workers is more common in childcare than in elderly care.

Elderly people in need of long-term care can opt for personal budgets. Expectation A5 asserted that cash allowances, especially when unregulated, lead to a demand for private informal migrant care workers. As reported above, in 2006 almost 10 percent of all AWBZ recipients chose to receive a personal budget instead of using in kind services. Contrary to the Italian attendance allowance, spending through personal budgets in the Netherlands is controlled (Ungerson 2003: 381), meaning that budget recipients have to keep track of how they spend the money and they have to report whom they employ. As a consequence, it cannot be used to employ an irregular migrant. In fact, many people use personal budgets to pay a relative to provide care services (Ungerson 2003: 391). Other workers employed through personal budgets are often individual professionals who have left the regular system (Kremer 2006: 391). These employees report being quite happy with this arrangement (ibid.: 393). It gives them the opportunity to develop a personal relationship with a client, it gives them independence, and it relieves them from all the bureaucracy that exists in care providing agencies (interviews with

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Sting and Ministry of Health – 2). So far there are no indications that the personal budget has led to an increase in the employment of migrant workers.

A very similar story can be told about the guest parent subsidy. Guest parents have to be registered by a guest parents' office (gastouderbureau). Since 2008, they also have to demonstrate that they are able to care for children, and they have to meet several other criteria, including having a command of the Dutch language (SIOD 2008: 11). In practice there are two types of guest parents: those who 'want to earn some extra money' such as grandparents and stay-at-home mums, and professional childminders, who are highly qualified. The use of the subsidy for the former group has been seen as an abuse, as will be further discussed below. Consequently, the subsidy has been made substantially more difficult to attain. Again, there are no signs that the subsidy is used for the informal employment of migrant workers.

In conclusion, the lack of migrant workers in private care seems to be related to a crowding out effect by publicly financed formal services in combination with a 'do it yourself' culture. That private migrant care workers are more prevalent in childcare might have a cultural reason. Controls on cash benefits seem to inhibit the employment of irregular migrants. These explanations will be further explored in a comparative perspective in chapter 6.

The impact of labour migration policies

Expectation A7 proposed that expansive immigration policies for migrant care workers could encourage their employment. Could it be that strict immigration policies have been an obstacle for the employment of migrant workers in the Dutch agency-based social care sector? In 2007, only 284 work permits were issued for the entire health and veterinary services sector, compared to a total of 50,000 (Interview Ministry of Justice). Although special arrangements for the attraction of skilled nurses have been made in the late 1990s, researchers have shown that these were hardly facilitating migrant care work, because they set strong restrictions on the entrance of these care workers (De Lange and Pool 2004; Roosblad 2005). The details of these policies will be further discussed below, but what stands out is that Dutch immigration policy has not encouraged the inflow of migrant workers.

In phone interviews with care providers in Amsterdam, only one organisation reported difficulties with obtaining work permits as an obstacle for employing migrant workers. In general, the migrant workers employed in social care came to the Netherlands either through family reunification or as asylum seekers. Moreover, since 2007 there are no restrictions anymore on the employment of Poles, but this has not led to the mass employment of Poles in the care sector. Strict immigration policies might make the employment of migrant workers

even less attractive, but they cannot be seen as the main reason for the lack of immigrants in the agency-based care sector.

The impact of strict immigration policies is more outspoken for private employment than for agency based employment. It is practically impossible to obtain a work-permit for private domestic or care services. Since there is nevertheless a demand for migrant domestic workers (at least in cleaning), migrants work irregularly. This finding confirms expectation A8, which proposed that restrictive immigration policies push immigrants into informal private employment. All interviewees testified that migrant domestic workers usually enter the Netherlands legally, on temporary tourist visas, as au pairs, as students, or as asylum seekers (e.g. interview Transnational Institute). They then overstay their permit and become illegal residents. For example:

> *[I]ndividuals from the former Soviet Union, Iran and Sri Lanka often came to the Netherlands as asylum seekers. When they were not granted refugee status they stayed in the Netherlands and became undocumented (Van der Leun and Kloosterman 2006: 66).*

According to researchers in the field of irregular migration, a recent tightening of controls on the employment of irregular immigrants has actually made it more attractive to be employed in private households than before because inspectors cannot in principal enter people's homes (Van der Leun and Kloosterman 2006; Van Walsum 2007).

In conclusion, Dutch labour migration policies do not provide many options for agency-based employment of migrant workers in social care, and they make the regular employment of migrant workers in private households virtually impossible. The strict labour migration and migration control policies instead push migrants into irregular private employment.

Recent developments

There are some recent developments in the elderly and child care sector that deserve consideration, because they partly contradict the general picture that has emerged so far. As reported above, the introduction of the Social Support Act (WMO) stirred up the home care sector. It seems to have led to a worsening of employment conditions. The turnover rate of employees in the home care sector suddenly increased from 12.1 percent in 2006 to 17.4 percent in 2008 (Prismant 2009b: 35). These developments could undermine the attractiveness of employment in social care. Although the figures cited above suggest a continuing job satisfaction among employees in the care sector, the image of the care sector might have been affected:

> *With the whole WMO episode, you make the social position of people working in the sector worse. Because you push them down. You say as a society: what*

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happens there, in home care, we actually find that less important; a cleaning organisation can do that (Interview Sting).

As a result of the WMO, home care workers have been made redundant and encouraged to start working as alpha helpers. This could potentially lead to large shortages in the sector in the long run when the economy improves again (Prismant 2008: 100). However, it should be remarked that the government has quickly responded to the negative and unintended consequences of the introduction of the WMO. These responses will be further discussed in the last part of this chapter.

In 2010, the SCP concluded that the number of heavily overburdened family carers had increased in seven years from 300,000 in 2001 to 450,000 in 2008. According to the SCP, this could be the consequence of retrenchments in the AWBZ and of the introduction of the WMO. Both developments place a more significant personal onus on individuals in need of care to arrange their care services privately and to rely on family carers (SCP 2010: 6). The overburdening of family care might eventually lead to a greater demand for cheap private services.

Finally, the marketisation of childcare services has led to a rapid growth of the sector but also to increasing concerns about the quality. One worry is that childcare providers would be more concerned with profitability than with delivering good care. Meanwhile, the government has lowered subsidies for childcare services, as will be discussed below. It could be that an increase in the costs together with a decrease in quality together lead to a larger demand for private (migrant) care, but this claim has not been verified empirically.

5.4 Policy developments: maintaining quality care

The previous section has shown that migrant workers have not (yet) become very common in Dutch social care. This section will investigate how policies have responded to this phenomenon. Of course it is problematic to investigate policy responses to a phenomenon that hardly exists. Therefore, the aims of this section are twofold. The first aim is to find out whether there are any policies that directly regulate or concern migrant care work. The second aim is to see whether there are indirectly related policy developments that encouraged or restricted the employment of migrant care workers. To better understand policy developments, some basic information on the Dutch political and policy making system will be presented first.

The Dutch electoral system is based on proportional representation. The Parliament consists of a Second Chamber, which is the main legislative body and is directly elected every four years, and a First Chamber (Senate), which is indirectly elected by province councils and only has a controlling responsibility. The country is always governed by a multi-party coalition

in which the biggest party delivers the Prime Minister. Table 5.5 shows the governing coalitions after 1994. Since the Second World War, only two governments did not include a Christian party (either the current Christian Democrats (CDA), or one of its Catholic or Protestant predecessors). These two coalitions were Kok I and II, consisting of the Labour Party (PvdA), the Liberals (VVD) and the Democrats (D66). Other important parties are the left-wing Socialist Party (SP) and GreenLeft (GroenLinks), as well as the social-conservative Christian Union (CU). Recently two populist right wing parties have become prominent in Dutch politics. First the List Pim Fortuyn – whose leader was murdered in 2002 – and then the Party for Freedom (PVV), led by Geert Wilders. These parties have introduced a strong anti-immigrant rhetoric into Dutch politics (Fennema and Van der Brug 2006), which will be further discussed below.

Table 5.6: Governing coalitions in the Netherlands, 1994- 2010

Cabinet	Period	Parties[1]	Acronyms
Kok I	1994-1998	**PvdA**, VVD, D66	PvdA = Labour Party VVD = Liberals D66 = Democrats (Progressive liberals) CDA = Christian Democrats LPF = List Pim Fortuyn CU = Christian Union
Kok II	1998-2002	**PvdA**, VVD, D66	
Balkenende I	2002-2002	**CDA**, LPF, VVD	
Balkenende II	2003-2006	**CDA**, VVD, D66	
Balkenende III	2006-2006	**CDA**, VVD	
Balkenende IV	2007-2010	**CDA**, PvdA, CU	

[1] The party in bold is the biggest coalition party which delivered the Prime Minister

Civil society and policy making used to be characterised by a strong 'pillarisation' in which organisations of Catholic, Protestant, Socialist and Liberal denominations cooperated with a political party belonging to the same group (Lijphart 1968). In the 1960s, pillarisation declined and since then interest organisations have engaged in more independent lobbying (Andeweg and Irwin 2002: 139). Nevertheless, they are still involved in the so-called 'poldermodel', a word used to describe consensual decision making on socio-economic policy (Visser and Hemerijck 1997). An important institution facilitating this cooperative policy making is the Socio-Economic Council (SER), which represents members of trade union confederations (in order of size: FNV, CNV and MHP) and employers' federations (the VNO-NCW, the general employers' federation; the MKB, for small and medium enterprises; and the LTO, for agricultural businesses). The SER frequently advises the government (ibid.: 143). Recently, it has been argued that the poldermodel is in demise. The government is less often inclined to wait for social partner advice and engages in more independent policy making (Delsen 2000).

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Labour migration policies

The availability of work permits for migrant care workers depends on their skill level and the type of work they will do in the Netherlands. For highly skilled nurses there were special programmes, but these were unsuccessful. In recent years, the number of skilled migrant workers entering the care sector has been very low, as was reported in the previous sections. For low skilled migrants, or for migrants employed by private households, it has not been possible to acquire a work permit. Only migrants from within the European Union can legally enter the Netherlands for such work.

This section will, first of all, briefly discuss the special programme for migrant nurses. At first sight, this could be seen as a directly encouraging measure, but it will be shown that this is actually doubtful. In any case, it was the only measure that directly concerned migrant care workers (see table 5.7). Regardless of requests for work permits for domestic workers and private care assistants, no exception has been made for this group of workers. The continuing restrictiveness of immigration policy for domestic workers and private care assistants or nannies will be discussed subsequently. Finally, the opening of the labour market for nationals from the countries that entered the EU in 2004, and the continued closure for nationals from Bulgaria and Romania is assessed.

Table 5.7: Dutch immigration policies related to migrant care work

	Direct policy responses	**Indirectly related policy developments**
Encouraging	(Unsuccessful experiments with attracting foreign nurses)	Opening of Dutch labour market for A8[1] nationals
Restrictive	No special arrangement for migrant domestic or private care workers	No permits issued for low-skilled workers from A2[2] or third countries

[1] The ten countries that joined the EU in 2004, minus Cyprus and Malta. A8 = Poland, Estonia, Latvia, Lithuania, Hungary, Czech Republic, Slovakia, Slovenia.
[2] The two countries that joined the EU in 2007: Romania and Bulgaria

In the late 1990s, importing foreign nurses into the country became a salient issue in the Netherlands. In the context of an economic boom and large labour shortages, foreign nurses became more attractive (Interview Ministry of Social Affairs and Employment – 2). In 2000, a special policy (*Convenant Arbeidsvoorziening Zorgsector, CAZ*) was introduced. It was signed

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by the social partners in the care sector. Only temporary – two years – employment of skilled foreign nurses, whose qualifications were recognised in the Netherlands, was allowed (De Lange et al. 2003: 21). The reason for this restrictive approach is presented in a revealing way in the following quote from the Organisation for Employment (*Arbeidsvoorziening*):

> *[B]y issuing temporary permits under strict conditions, the structural admission of large numbers of foreigners to a particular sector should be avoided. In other words, a repeat of the 1960s, when so-called guestworkers came to the Netherlands in large numbers, should be avoided wherever possible. In the view of the Organisation for Employment such an admission of foreigners would not be in the interests of the sector itself. The policy to attract more jobseekers in the Netherlands to the sector through recruitment campaigns and training would be undermined by it. In addition, there is the chance that if a turnaround occurs in the labour market, qualified labour supply has no chance of finding a job in the care sector (cited in De Lange and Pool 2004: 133, author's translation).*

There were a range of requirements that had to be fulfilled by employers before they could employ a migrant nurse. In the end, according to De Lange and Pool, the special Covenant made it more difficult to attract a foreign nurse than it was under the normal Law on Foreign Labour (WAV) (2004: 134). The fact that the employers' organisations nevertheless agreed to the Covenant, so explained by De Lange and Pool, was related to their ambivalent position towards immigration in the first place. They were not convinced that immigration was the best solution for shortages in the care sector. The trade unions would have agreed because they did not want to be seen in the media as the cause for 'empty surgeries'. Politically, one central issue of contention was the potential 'brain drain'. The government had to promise that work permits would only be issued to people from countries that had no shortage of nurses (De Lange et al. 2003: 22).

In any case, the attraction of foreign labour was considered to be a failure, for reasons that were already discussed before. This failure has implications for current policy on labour migration in the care sector:

> *Occasionally someone proposes to fly in people from South Africa, but thinking about the projects from the 1990s I think that is of little use, because you will encounter exactly the same problems again (Ministry of Social Affairs – 2).*

Instead, the general line now is:

> *if there are labour market shortages, then we should resolve those internally in the Netherlands, instead of recruiting abroad (Interview Ministry of Justice).*

This position is supported by the Ministry of Health, which advises the Centre for Work and Income on the need for skilled migrant labour. Interest organisations in the sector, too, have not undertaken action to reverse this position.

So far the discussion concerned skilled labour. For the less skilled care assistant jobs, it is questionable whether a permit would be issued even if there was a large demand because:

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'when it involves care, especially home care, then it's all low-skilled work' (Interview Ministry of Justice). In general a work permit is only issued when there seems to be a shortage of suitable labour supply. For low-skilled jobs, the general line is that a sufficient national labour supply is available. There are people on unemployment and disability benefits who could start to work again. Participation rates of women and older people should rise. These are all priorities that come before turning to labour migration.

A similarly restrictive position exists relating to domestic workers and privately employed carers even though 'it is known that in personal care there are (especially female) labour migrants from developing countries.' (SER 2007: 38). The Socio-economic Council even recognises that:

> *In the light of potential bottlenecks in formal care it is possible that people will to an increasing extent organize their own care, and that they increasingly want to use (legal or illegal) cheap foreign labour providing personal services (SER 2007: 38).*

Nevertheless, the domestic work sector is not considered to be a sector with shortages in the Netherlands:

> *They exist. We know they exist and we know that less pleasant things occur within households. But it is outside of our vision (Interview Ministry of Social Affairs – 2).*

Why are there no work permits issued for domestic workers and personal carers? In fact, several organisations have recommended that issuing work permits to domestic workers should be considered[64]. Migrant domestic workers have also organised themselves to lobby for work permits[65]. This group, however, is small and politically weak. As in the UK, domestic workers have tried to gain support from trade unions. One union (the AbvaKabo) did allow undocumented domestic workers to become members of the union. However, it was not prepared to publicly demand a regularisation or work permit for these domestic workers.

> *This is the contention we have now with the trade union. [...] Because they don't want to involve themselves in confronting the Parliamentarians. Because they say it's political. They don't like that (Interview CFMW).*

The unwillingness of the trade union to lobby for regularisation fits in with trade unions' general fear of immigration issues:

> *'The big problem is of course that if there would be a work permit for domestic work, people would have the idea that we would open all the borders (Interview Abvakabo).*

[64] For example by E-Quality – a think-tank on emancipation and a multicultural society – in a letter to Parliament on 1-4-2004.
[65] Most notably the CFMW, the Commission for Filipino Migrant Workers, and Trusted, an organisation of migrant domestic workers in the Netherlands.

This finding fits with the expectation (C1), formulated in chapter 2, that trade unions take an ambivalent position. As the representative of a migrants' rights organisation put it:

> *The situation over the last 4 or 5 years has been extremely negative in relation to migrants. By that I mean the media. It has become highly politicised, the treatment by political parties and it particularly seems to be defined by the way in which the far right [...] have been defining the agenda. [...] And this has very much defined the debate in the public (Interview Transnational Institute).*

The quote confirms expectation C3, proposing that the electoral strength of radical right parties leads to a more restrictive immigration policies. In the Netherlands, political actors and interest groups, both on the left and on the right of the political spectrum fear that coming out in favour of expansive immigration policies would cause public repercussions. As a consequence, the result has been negative:

> *We have had this discussion [...] shouldn't we create more legal options for domestic workers? [...] Well, no, there simply is no political support, because why would you do it for this type of low-skilled labour and not for other types? (Interview Ministry of Justice)*

In fact, there are special schemes for other sectors, such as agriculture, regardless of the very strong anti-immigrant sentiments. The difference with the domestic work sector is that these other sectors are much better organised[66]. In domestic work, there is no association of employers lobbying actively for special schemes for migrant workers (Interview Ministry of Employment and Social Affairs - 3). Through lobbying and extensive proof of the difficulty of finding suitable labour, other sectors demonstrate their needs and convince bureaucrats and politicians. Comparing the domestic work situation with agriculture a civil servant concluded:

> *But there they really don't manage to find people, and of course the agricultural lobby is very tightly organised, they just have a very good political lobby in The Hague. Domestic workers, these are all families, they don't have an organisation that can make an impact in The Hague (Interview Ministry of Justice).*

As long as the domestic work sector stays as hidden and informal as it is now, it is unlikely that employees or employers will be able to organise and lobby effectively for work permits.

To summarize, strong anti-immigrant sentiments – voiced by right-wing populist parties – have made the Dutch government very reluctant to enact any expansive immigration policy. The domestic work sector lacks a well-organised lobby which can convince the government to enact expansive policies regardless of this general position. These findings support the expectations formulated in chapter 2 regarding the influence of the radical right (C3) and the importance of strong employers' organisations (C1).

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[66] As was suggested in: E-Quality, *Vrouwelijke arbeidsmigratie uit de nieuwe EU-lidstaten, (plaatsvervangend) leden van de Vaste Kamercommissie voor Sociale Zaken en Werkgelegenheid*, 1 April 2004.

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A final policy development to be discussed, since it potentially affects care workers from Eastern Europe, is the lifting of labour market restrictions on A8 nationals in 2007. The government intended to open the Dutch labour market for migrant workers from these new Eastern and Central European member states back in 2004. However, there was substantial opposition to this idea. While employers' organisations were in favour of opening the labour market, trade unions were sceptical. They were afraid of potentially large inflows of Polish workers who would crowd out Dutch employees, because they would accept employment conditions at a lower standard than native workers.

In Parliament the Socialist Party (SP) represented the fear of the trade unions by fiercely opposing the opening of the labour market. Other political parties soon followed this example. Both the Labour Party (PvdA) and the Christian Democrats (CDA) did not want to carry the political risk of taking an unpopular decision. Even the Liberals (VVD), who initially sided with the employers' organisations, made a U-turn and opposed opening the labour market in the end.

In response to all these fears, the government undertook actions to fight irregular employment. A penalty was introduced in the Minimum Wage Act making employers who did not comply with the law liable for the payment of substantial fines. Labour inspections were expanded and special hotlines were opened up where trade unions could report abuses and underpayment. In addition, local governments were consulted in order to develop a housing policy for newly arrived immigrants. Finally, in 2007, in the context of a tightening labour market, politicians agreed that there was sufficient action undertaken to allow lifting the restrictions on A8 citizens. Nevertheless, the trade unions remained critical.

At the time of writing there was no support for opening the labour market for workers from Bulgaria and Romania. Although the labour market situation was still positive in 2008, the economic crisis has changed that. With high unemployment levels, it is unlikely that Bulgarians and Romanians will be allowed to work in the Netherlands any time soon.

In conclusion, the economic situation forms an important starting point for immigration policies. When the economy is doing well, unemployment is low and the labour market is tight, there is more demand for migrant labour. In these times the government is also – under certain circumstances – more willing to allow for (temporary) labour immigration, as occurred with the experiments to attract foreign nurses in the 1990s. Meanwhile, the rise of anti-immigrant parties and the growing electoral strength of populist right wing parties have strongly influenced the debate around immigration policy. All political parties, as well as trade unions, have become very careful when deciding whether to support expansive immigration policies or not. The result has been that only well organised employers' lobbies, such as in the agricultural sector, could

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successfully convince the government of a need for temporary work permits. In this context, the weak lobby behind domestic workers did not have a chance.

Child care

With the rapid expansion of the childcare sector, there was a strong need for new employees. However, the attraction of migrant workers was never an issue and there have been no policies directly related to migrant care work in the childcare sector. There are, however, some policy developments that could be indirectly related to the attractiveness of migrant workers. First of all, the very large expansion of investments in agency-based childcare might well have had a crowding out effect on the demand for private migrant care. Second, the availability of a guest parent subsidy could have encouraged private migrant care, though only on a formal base. The recent restrictions on guest parent subsidies have reversed this trend. It should be noted that these policy developments are only related to migrant care work on a theoretical base. Nevertheless, looking at the dynamics behind them is revealing for what is happening in the childcare sector in the Netherlands.

Table 5.8: Dutch childcare policies related to migrant care work

	Direct policy responses	**Indirectly related policy developments**
Encouraging	-	- The availability of guest parent subsidies (?) - The recent retrenchments of childcare subsidies
Discouraging	-	- Large investments in childcare availability and in training of staff - Strengthening control on guest parents

Until 2005, the only legal regulations governing childcare were part of the Social Assistance Act (Welzijnswet). During the coalition agreement of 1998, the Dutch government declared its intention to develop a new comprehensive law on childcare (Regering 1998: 10, 24). There was a strong consensus among the coalition partners (PvdA, VVD, D66) that there was a need for a (new) law, but there was disagreement about the exact terms and conditions that should be applied, especially in relation to how childcare should be regulated and financed. While the Labour Party favoured some kind of basic provision for all children, financed through collective means and organised by local governments, the other coalition partners, as well as other

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important actors in the sector[67], favoured a demand-led system, in which parents would receive direct subsidies and were free to choose which form of (market-provided) childcare they preferred. Eventually, an agreement was reached on a demand-led system, but the final decision was taken by Balkenende II, a Christian Democrats/Liberals government.

As discussed before, the Law on Childcare was an enormous success, especially after employers' contributions were made mandatory in 2007. As a consequence, the demand for staff increased sharply, with a rise of 8 percent per year. Finding suitable staff has been an important concern of the sector (Prismant 2009a), one that was also addressed by both government and social partners. With the introduction of the demand-led system, the government has lost all direct responsibility for staff, etc. They have, however, maintained some control on the quality of care. Investments in the quality of care, which amounts to some 10 million Euros a year, have largely gone into the recruitment of new staff. In addition, there are special regulations for the recognition of diplomas obtained in other sectors or through experience (Prismant 2009a: 116). At the same time, employers' organisations and trade unions have started a joint recruitment programme. Together, these programmes seem to have had a significant effect, as turn-over rates went down from 14.6% in 2004 to 10.8% in 2008[68] (Prismant 2009a: 119).

Meanwhile, the childcare sector grew so quickly that in 2008 concerns were raised about its costs. In spring 2008, Prime Minister Balkenende stated that it was 'doubtful whether more people will start to work when more money is invested in childcare'[69]. Soon after that, Finance Minister Bos announced that restrictions of the childcare subsidy were necessary. Consequently, in autumn 2008 public childcare subsidies were lowered, but only marginally. A year later they were decreased again.

The main worry about the childcare law concerned the massive increase in usage of guest parent subsidies. It was generally believed that the system was abused to pay grandmothers (the 'oppas oma') or neighbours who would have looked after their grandchildren anyway, with or without a subsidy. Therefore, in 2008 eligibility criteria were tightened. Among the new requirements were the vague notion of 'knowledge of the development of children' and a 'good command of the Dutch language' (SIOD 2008: 11). In 2009 it was decided to end public subsidies for informal guest parents. Only 'mini-crèches', in which a childminder takes care of several children, are still eligible for public subsidies, but only if they fulfil certain quality criteria.

[67] The parents' organisation BOINK as well as all big providers of childcare services.
[68] Of course it should be noted that the economic crisis might also have contributed towards lower turn-over rates.
[69] *De Volkskrant*, Kabinet snijdt in kinderopvang, 26 April 2008

Interestingly, in the whole discussion about the unintended use of guest parent subsidies, there was no reference to the use of these subsidies to employ (foreign) nannies. Nevertheless, the hiring of nannies has been affected by the recent changes. Concerns about the abuse of childcare subsidies for informal family care thus have potential implications for the nanny/au pair sector. Unintentionally, the government has undertaken steps with which it might discourage the private employment of a migrant child carer.

What stands out in all the developments of childcare policies is the attention given to increasing the labour market participation of women. The main reason why investments could be expanded so quickly, was the belief that this would lead to higher labour market participation rates and hence to economic growth (Interview Ministry of Social Affairs and Employment – 3, Interview Childcare consultant). It is in this context that we can understand that the Liberals – generally against increasing public expenditure on social services – favoured publicly financed childcare, and that even the Christian Democrats – generally in favour of family care – did in the end not object to the new Law on Childcare. The argument united political parties who otherwise strongly disagreed on the issue.

Elderly care

The direct response to migrant work in elderly care in the Netherlands is the explicit consideration that attracting migrant workers is not a good solution for emerging shortages in the sector. There are some other policies indirectly related to the (lack of) employment of migrant workers. In general, large investments in long-term care and, in particular, investments in training and education of staff have contributed to the limited demand for migrant workers. At the same time, however, recent developments – especially the introduction of the WMO – seem to have led to the casualisation of work and may have made the sector less attractive for employees. In that respect, there is a contradiction between the explicit and direct policy of not opting for migrant labour on the one hand, and developments in the WMO and retrenchments of the long-term care insurance on the other hand.

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Table 5.9: Dutch elderly care policies related to migrant care work

	Direct policy responses	Indirectly related policy developments
Encouraging	-	- Unintended consequences of WMO - Alpha helpers and regulation for personal service provision - Emphasis on family care ('mantelzorg')
Discouraging	- Migrant labour not considered as a solution for staff shortages	- Continuous large investments in long-term care, including in staff in training/recruitment - Strict controls on Personal Budgets

Public investments in elderly care as a percentage of GDP have increased in the 1990s and early 2000s (see table 5.6). This was related to an increasing demand for care services, and to the political will to meet these needs. In the 1990s, public concern about waiting lists emerged and in 1998 the new government (Kok II) committed itself to combating waiting lists, both in the "cure" and in the "care" sector[70]. In 1999 it was announced that the government would set aside an additional 1.3 billion Euros to target waiting lists until 2002[71]. Later that year, in a series of court rulings, judges ruled that all AWBZ-insured citizens (i.e. all Dutch citizens) had the right to receive appropriate long term care[72] (Pijl and Ramakers 2007: 85). These rulings suggested that the government was responsible for care provision, whether costs were covered by the insurance scheme or not. Receiving care services was an entitlement for every Dutch citizen in need of long-term care. In reaction to these rulings the government reinforced and intensified the efforts to combat waiting lists[73]. The initiatives were quite successful, as waiting lists decreased[74].

[70] VWS, Brief aan de Tweede Kamer der Staten Generaal, 'Meerjarenafspraken zorgsector', 1998, FEZ-U-981147
[71] VWS, Persbericht, '1,6 Miljard voor aanpak wachtlijsten verpleging en verzorging en werkdruk; 6-7-1999
[72] See also the following newspaper articles: NRC, De Volkskrant, 'Werk wachtlijsten zorg weg met verhoging AWBZ-premie', 2-11-1999; 'Zorg afdwingen via een gerechtelijke procedure, 9-12-1999.
[73] VWS, Persbericht, 'Kabinet volgt de vraag bij de AWBZ, 28-6-2000; VWS, Kamerstuk, 'Investeringen in de wachtlijstaanpak, 4-12-2000, PBO/2135028
[74] VWS, Persbericht, 'Wachtlijsten verpleging en verzorging met 20% gedaald', 23-4-2001

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Table 5.10: AWBZ budget and total expenses on elderly care services as percentage of GDP

	AWBZ budget	Total expenses on elderly care
1975	1.74	1.13
1985	2.21	1.44
1995	3.94[1]	…
2000	3.47	2.08
2003	4.27	2.57
2005	4.29	2.47
2006	4.28	2.48
2007	4.04	2.48

Source: CBS (2009)
AWBZ = Long-term care insurance; Figures include clients' own contributions.
[1] In 1995 some forms of care were temporarily brought under the AWBZ, but were removed again soon after.

In order to achieve a growth of provision, new staff was needed. Therefore, large investments were made to decrease the workload of employees and there was an intensive cooperation with the social partners regarding labour shortages and the improvement of employment conditions[75]. In this context, the earlier mentioned experiment with the employment of migrant nurses was carried out, but these experiments only formed a very small part of the entire package.

One of the steps that were taken to quickly decrease waiting lists was to encourage the use of Personal Budgets ('Persoonsgebonden Budget') (Pijl and Ramakers 2007: 85). Experiments with Personal Budgets had already started a decade before, being strongly promoted by the Disability Council (Kremer 2006: 387). The budget consisted of cash payments with which a person in need of care can purchase care services. In 1995, the Personal Budget was introduced for a selected group of AWBZ users. This group was gradually expanded in subsequent years. Until 2001 there was a maximum budget available for PBs, which resulted in waiting lists (ibid.: 389). In 2001 budgetary restrictions were lifted, meaning that everyone entitled to receive care could opt for a Personal Budget.

Yet the expansion of elderly care services under Kok II came at substantial costs. These costs were subsequently translated into higher mandatory contributions payable for the AWBZ, which rose from 9.6 percent of gross wages in 1998 to 13 percent in 2004[76]. In 2003, the new Christian-Democratic/Liberal government announced in its coalition agreement that measures had to be taken in order to prevent the uncontrollable growth of the AWBZ. These measures included the tightening of eligibility criteria and higher out-of-pocket contributions (Regering

[75] VWS, Brief aan de Tweede Kamer der Staten Generaal, 'Meerjarenafspraken zorgsector', 1998, FEZ-U-981147.
[76] VWS, Brief aan de Tweede Kamer der Staten-Generaal, 2003, DBO-U-2412236.

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2003: 8-9). The new government emphasised that: 'In principal, state responsibility ends literally at the front door'[77]. A problem with the existing system would be that informal help was too often and too easily replaced by an appeal to the public system. The share of responsibilities between state and citizen had to be redefined.

In 2004, co-payments for services were increased and eligibility criteria were tightened. Criteria were developed to assess which caring tasks could be expected to be provided by household members, referred to as 'common care' ('gebruikelijke zorg'). Professional help should only be provided for those care tasks that exceeded 'common care' (Morée 2006). Though all these are forms of retrenchment, they have not really altered the system. The introduction of the Social Support Act had a more substantial impact, as will be discussed below.

Simultaneously, plans were made to remove home help services from the AWBZ and make it part of a social assistance programme administered by local governments. After a series of debates and amendments, the Social Support Act (WMO, Wet Maatschappelijke Ondersteuning) received broad Parliamentary support. Only the Socialist Party continued to oppose the law. Interest organisations were also in favour of the new law. Employers were especially keen because they believed that the marketization of home help services would be profitable (Interview Ministry of Health, Welfare and Sport – 2). It turned out quite differently from what had been envisaged. The competition encouraged home care providers to provide services below their actual costs. As a direct result many providers got into financial trouble. In response to these difficulties, some providers fired their personnel and encouraged them to work as 'alpha helpers' instead (Prismant 2009a: 93).

This development received much public attention. While home care providers went bankrupt, trade unions were outraged by the lay-offs and Parliamentarians (especially from the Socialist Party) bombarded the government with critical questions. The government reacted quickly, because: 'it [was] not the intention that these people disappear from the sector' (Interview Ministry of Health, Welfare and Sport: 2). Among the measures introduced in 2008 was the establishment of mobility centres, which helped home carers to find new employment; there were new investments in training (20 million) to improve home care workers' career opportunities; and an additional 40 million was set aside for organisations who regularly employed alpha helpers (Prismant 2009a: 94). This seems to have slowed down the trend of staff leaving the sector. According to a civil servant of the Ministry of Health:

> *I hear about it less often, that people don't stay but go and work at Albert Heijn. Of course I still hear about it every now and then [...], but it's not that massive anymore (Interview Ministry of Health, Welfare and Sport h – 2).*

[77] VWS, Brief aan de Tweede Kamer der Staten-Generaal, 2003, DBO-U-2412236 [*Ibid*?]

Due to the economic crisis, acute staff problems for the care sector as a whole have decreased. Nevertheless, labour market issues continue to be a central concern for the government and for employers' organisations. There is a Direction of Labour Market Policy (MEVA) at the ministry. Policies introduced by this direction involve training, an educational fund, and the encouragement of internships. There are stimulation programmes to attract people who worked in other sectors before. In addition, an important objective is to facilitate the combination of care for relatives with a professional care job (Interview Ministry of Health, Welfare and Sport – 2)[78].

Meanwhile, most concerned actors do not consider immigration as a solution for current or future staff shortages. There are concerns about the quality of care that immigrants can provide:

> *We say it is not quality care to attract a bucket of immigrants who don't speak the language, [and let them work] with very vulnerable people who already have difficulty communicating. Communication is a big part of care. You can't do that, that's not quality (Interview Ministry of Health – 2).*

Another argument used is brain drain, as can be read on a weblog of Abvakabo leader Snoei:

> *The recruitment of nurses abroad is not a solution we propagate. We should not collaborate with the draining of nurses from countries that have shortages themselves* [79].

In response to this continuous fear of contributing to brain drain, care providers collaboratively developed a certificate for the recruitment of foreign care workers[80]. It was introduced just before the economic crisis and it did not receive much attention afterwards. Although the recruitment of foreign workers is not a current priority for care providers, it is apparently still considered to be an option for the future.

In response to current and future labour shortages, recent governments have chosen to stimulate the provision of informal family care, so called 'mantelzorg'. Examples are the above mentioned 'common care'. One of the objectives of the WMO was also to promote family care as an alternative for formal services (De Klerk et al. 2010: 251). As was brought forward in section 5.3, this has put family carers under pressure. It even encouraged some of them to stop working (EIZ 2008)[81]. So far, the only government response has been to encourage employers to create flexible circumstances[82]; but the fact that family care is perhaps not a resource that can be expanded indefinitely is not a central consideration.

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[78] See also, for example: VWS, Brief aan de Tweede Kamer der Staten-Generaal, Arbeidsmarktbrief 2008, MEVA/ABA2900709, 23 December 2008.
[79] http://www.abvakabofnv.nl/nieuws/weblogedithsnoey/, 22-07-2005.
[80] 'Keurmerk voor bemiddeling buitenlandse zorgwerknemers', press release Brancheorganisatie Zorg, 24/06/2008.
[81] VWS, Antwoord op Kamervragen, 13 augustus 2010, DMO, 3015175.
[82] VWS, Antwoord op Kamervragen, 13 augustus 2010, DMO, 3015175.

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As was discussed in section 5.3, Personal Budgets can be, and in practice often are, used to pay for family care. But the personal budget is also intended for the purchase of services on the care market. Ungerson notes that in the Netherlands, contrary to developments in many other countries, the PGB 'has been more and more subject to regulation' (Ungerson 2003: 384). According to Pijl and Ramakers, the explicit motivation for maintaining strict control on PGB-spending was the government's fear that care workers might otherwise be hired on the grey market (Pijl and Ramakers 2007: 84, 87), which was apparently considered to be undesirable.

What stands out in Dutch elderly care is a continuous tension between the willingness to provide quality services on the one hand, and a need to contain rising costs on the other. There are some differences in parties' preferences that are in line with what was expected in chapter 2 (expectation B2). While the Liberals are often in favour of marketisation, the Christian Democrats want to encourage and support family care. The Labour Party, and more outspokenly the Socialist Party, are in favour of state involvement. However, among all parties, except perhaps the Socialist Party:

> *There is a general awareness of the necessity for constraint [of the costs][…] That urgency is felt. And there is the awareness that together we have to arrange something for people who are really vulnerable, something involving solidarity (Interview Ministry of Health – 2).*

The balancing between quality services and cost containment is strongly influenced by the social partners. Providers' organisations, clients' organisations, professional organsiations, and (to a somewhat lesser extent) trade unions are all very actively involved in policy making (Interview Ministry of Health – 2). In this respect expectation B3, which predicted that beneficiaries of care services are politically weak, is not confirmed. Providers and clients' organisations were, for example, very quick to react to the unintended consequences of the WMO, and lobbied the government for actions in order to reverse these negative consequences. It can be ascribed to the cooperative efforts of the social partners and the state that employment conditions in the social care sector are still decent, and that enough people are trained.

The explicit intention of both the government and the social partners has clearly been to solve labour shortages nationally. The belief that migrant workers are not a solution for such shortages might even have reinforced the aim to invest in a native labour force (cf De Lange 2004). However, the will to contain costs seems to have gotten the upperhand in recent years. After the expansive Kok II period, the various Balkenende governments – both those with the Liberals and the one with the Labour Party – have gradually cut expenditures (see table 5.10). With the financial crisis of 2008, retrenchment has become an even more salient objective. However, the new government that took office in 2010 – a minority government of CDA and VVD supported by the populist right-wing PVV of Geert Wilders – has declared that it will cut

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many government expenses, but that it will not retrench elderly care. Interestingly, it was the PVV of Geert Wilders that had the strongest opposition against cuts in elderly care services. There is no indication that the potential future demand for migrant workers has informed Wilders' preferences, but nevertheless his opposition against cuts in elderly care might contribute to continuing the limited demand for migrant workers in the elderly care sector.

A market for personal services

In recent years, the reliance of households on domestic workers has increasingly become a political issue. It has been recognised that with more and more women employed, there was a demand to be met. In addition: 'The market for personal services is an ideal sector to get people to work. It creates employment opportunities at the lower end' (Interview Ministry of Social Affairs and Employment – 1). However, most work in personal services occurred on an informal basis. In 1998, the government introduced a programme for cleaning services for private households (Regeling Schoonmaakdiensten Particulieren, RSP). The idea was to subsidize cleaning companies who would employ long-term unemployed people to clean in private households. But the project was unsuccessful, because there was a lack of unemployed people wanting to participate in the programme.

When the government decided to abolish the RSP it had become quite a sensitive political issue. Parliamentarians urgently requested the government to come up with an alternative. Several organisations, such as the Central Planning Bureau (CPB 2005), a research institute (SEOR 2004) and the Council for Work and Income (RWI 2005) were asked for advice. One of the recommendations of the latter was to make the costs of hiring a domestic worker tax deductible. This proposal was popular in Parliament, especially among left leaning parties (GroenLinks, SP, PvdA). But the government was not in favour of it. Other costly ideas, such as the Belgian example of a subsidized voucher scheme[83], were also received with scepticism:

> *And we wonder: should you want that? Is it worth it, to create a few little jobs at the lower side of the labour market [...]? We really want to get it from the black market to the regular market, but not if that takes so much money (Ministry of Social Affairs – 1).*

In the end, the government opted for a regularisation of the existing situation. Under the new 'Regulation private service provision' (Regeling dienstverlening aan huis) private employers of domestic workers are exempted from paying taxes and social security contributions, provided

[83] In Belgium households can purchase publicly subsidized vouchers which they can use for domestic services provided by agency-based employees.

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that they hire the domestic worker for a maximum of three days a week. In order to make the new regulation as accessible as possible, the government prescribed no obligations to register the employment relationship. This system excludes the worker from social security benefits and many elements of employment protection. The alpha helper, who provides home care services, also falls under the new regulation.

Some political parties, especially the Socialist Party, have remained sceptical about this arrangement that exempts domestic workers and alpha helpers from social security protection. But there is no political support for a more costly regulation:

> *And how can you justify doing this for domestic work? [...] Why wouldn't you subsidise other sectors? That really preoccupies us (Interview Ministry of Social Affairs and Employment - 1).*

The lack of social protection is justified by reference to the idea that these employees will usually have a husband whom they can rely on:

> *the people who offer these services are often partners of working people, often women who just want to do something extra for one morning (Interview Ministry of Social Affairs and Employment - I).*

Something that is rarely considered in the whole discussion about private service provision is the fact that many domestic workers are in fact undocumented immigrants. Their presence is largely ignored. With the Regulation private service provision and its complete lack of registration and control, domestic work will continue to be a hidden and largely informal sector. It is therefore likely that it will also continue to be an attractive sector for undocumented immigrants.

5.5 Conclusion

Although evidence is scarce, it can be concluded that migrant workers in social care are rather uncommon in the Netherlands, with the exception of long-term care institutions in the bigger cities and some privately employed au pairs and nannies. The explanation for the lack of migrant workers in private informal care relates to the scale of publicly financed service provision, in combination with a Calvinist 'do it yourself' attitude. The lack of migrants in formal agency-based care is related to the large public investments in training and employment conditions, and the close cooperation with the social partners in the sector.

The direct policy response to migrant care work in the Netherlands has been discouraging. First of all, migrant workers are not considered to constitute a solution for staff shortages in the formal care sector. Second, obtaining a work permit for private care work is practically impossible. The negative attitudes regarding migrant care workers are induced by the generally strong anti-immigrant sentiments expressed by anti-immigrant parties. Interestingly,

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the negative perception of immigration in agency-based care seems to have reinforced the recruitment and training of native staff, especially under Kok II (1998-2002), which made very large investments in this sector.

The consecutive Balkenende governments have retrenched elderly care services, and have also – since 2008 – cut childcare subsidies. These retrenchments have put family members under greater pressure to provide care services for their dependent relatives, while the introduction of the WMO has had negative consequences for the agency-based home care labour force. These developments might lead to future staff shortages in the home care sector, and to a greater demand for informal private care services, possibly provided by (irregular) immigrants.

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6 WHY MIGRANTS WORK IN SOCIAL CARE

The three preceding chapters discussed the employment of migrant workers in social care within three different national contexts. It has become clear that both the numbers of migrant workers employed, and the type of employment they are engaged in, differ widely by country. This chapter will compare the findings from these three case studies. It concentrates on the first set of research questions: Why do families and/or care providers rely on migrant care workers? And why does the importance of migrant care workers differ by country and by type of care provided? The next chapter will discuss the second research question concerning policy developments.

The first section hereafter draws an overview of the types of employment of migrant care workers in child and elderly care in each of the countries. In the rest of the chapter, potential explanations for commonalities and variations in migrant care work are discussed. The expectations formulated in chapter 2 are used to structure the analysis. In the second section, the working conditions of migrant workers in the different countries and sectors are compared. This section assesses whether there are differences between the employment conditions of migrant and native workers in similar types of employment, and whether there are cross-national similarities in the circumstances under which migrants are employed. The third section evaluates the impact of different labour market regimes. The fourth section focuses on the impact of social policies and social care systems and the fifth section addresses the importance of immigration policies. To conclude, the last section briefly addresses the influence of economic circumstances and the impact of the economic crisis that started in 2008.

6.1 The importance of migrant care workers: a summary

In the previous chapters various kinds of data sources were used to describe in which types of social care migrants are employed. Here, the main findings of these chapters are briefly summarised. For information on and references to the specific data sources used, the country case study chapters should be consulted.

In Italy, a large number of migrant workers are directly employed by families. They often work as care assistants for dependent elderly people, as part-time cleaners, or – to a lesser extent – as baby-sitters. The total number of migrants regularly employed by families as domestic and care workers increased from 35,740 in 1991 to 464,033 in 2007 (see figure 3.1). By 2007, 78 percent of all domestic workers and private care assistants regularly employed

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were foreign (INPS 2009). Especially the phenomenon of care assistants caring for older family members has grown substantially in recent years. Exact figures are impossible to give, since some migrants are employed irregularly. Nevertheless, it is clear that hundreds of thousands of Italian families privately hire migrant care workers. Many of these migrant workers live-in with their employers. Most migrant workers currently employed came from Eastern Europe (especially Romania and Ukraine), followed by migrant workers from South America and the Philippines (see table 3.4). The employment of migrant workers in agency-based elderly care is much more limited. In 2005, foreign nurses employed in health and social care formed only 2 percent of the total workforce (OECD 2008b: 12). Because the importance of migrant workers in agency-based care pales in comparison with private employment, it was not further explored in the Italian case study chapter.

In the United Kingdom, migrant workers are overrepresented in formal agency-based elderly care. An analysis of the UK Labour Force Survey (2008, 4th quartile) showed that the share of migrant (foreign-born) workers among care assistants and home carers in England is 20.7 percent compared to 14.2 percent in the total labour force (see table 4.3). On the other hand, migrant workers are clearly underrepresented in agency-based childcare settings. It is difficult to say how many work in private elderly care, but this number seems to be relatively low. More important is the employment of foreign childminders and nannies. The latter often come from new EU member states, while care assistants working in elderly care are more often from outside of the EU, primarily from African Commonwealth countries and from the Philippines (table 4.5).

In the Netherlands, migrant workers are generally less common in caring occupations. They are underrepresented in agency-based care settings (see table 5.3), although there are some migrant workers employed by elderly care providers in the bigger cities. Little is known about the employment of migrant workers in private (informal) settings, but this seems to be quite rare in elderly care, while it is slightly more common in childcare (au-pairs, nannies). Most common is the employment of migrant workers, often irregularly present in the Netherlands, as housekeepers.

Table 6.1 summarises the findings of the three case studies. Comparing quantities of migrant workers across countries is difficult, because very different data sources were used. Moreover, in some countries no quantitative data were available at all and therefore indicators are based only on interviews and anecdotic evidence. As a consequence, the information presented in table 6.1 should be seen only as an indication.

Table 6.1: The employment of migrant workers in different types of social care employment

		Italy	UK	Netherlands
Elderly care	**Agency-based**	**+/-**	**+**	**-**
	Private	**++**	**+/-**	**-**
Childcare	**Agency-based**	**...**	**-**	**-**
	Private	**+/-**	**+**	**+/-**

Index: - = few; +/- = some; + = more, ++ = many; ... = no data available; +/- refers to a similar share of migrant labour as in the total labour force.

6.2 Employment conditions and migrant workers

In chapter 2 a number of possible explanations for the employment of migrant care workers were presented. The first expectation to be considered concerns the working conditions of migrant workers:

A1 Migrant workers are employed in "bad" jobs characterised by unpleasant working conditions, limited chances of job mobility, a personal relationship with the employer, and possibly by low pay.

This expectation regarding "bad" jobs has implications on two levels. First, it could be that migrants as a group are more often employed under these conditions than their native colleagues. Second, it could be that the employment conditions in social care (or any other sector) generally resemble these "bad" job characteristics, thereby inducing a demand for migrant workers in the sector. Both these options are considered below, starting with a comparison of the employment conditions of migrant and native workers.

Italian family survey data show that in Italy migrant domestic workers, baby-sitters and elderly care assistants are much more likely to live with their employer than their native peers (see table 3.8). Among foreign care assistants caring for an older person, 43 percent lived with their employer, compared with only 7 percent of Italian care assistants. Another survey of migrant domestic workers showed that live-in care assistants work on average 59 hours per week (Iref 2007: 31). They have little time off, and are often on call during the night.

Data from the UK Labour Force Survey showed that in England foreign care assistants and home care workers work more hours and more night-shifts than British care assistants (see table 4.10). The difference in the latter is especially striking: of all foreign care assistants, 61 percent worked night-shifts, compared to only 22 percent of the British. Foreign care assistants are more likely to work in the private sector, which is characterised by lower wages and worse employment conditions than the public sector. The results of a survey of care providers

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(Cangiano et al. 2009) even suggest that many employers hire migrant workers precisely because they are willing to work unsocial hours for low wages.

The UK data analysed in chapter 4 do not support the idea that migrant workers earn less than native employees. When controlling for age, the wage difference between migrant and native workers disappears completely. Finally, foreign childminders are more often employed by a private household than native childminders, who work most frequently for agencies. To conclude, in the UK migrant workers more often work in agency-based jobs that involve long working hours and nightshifts, and in private jobs that involve a personal relationship with the employer(s).

There are no micro-level data available for the Netherlands. Therefore, conclusions have to be based only on the Italian and British cases. Findings in these two cases mostly confirm expectation A1. Migrant workers in both Italy and the UK work longer hours and more (night) shifts than their native colleagues. Besides, childminders in the UK are more often employed by private households, and care assistants in Italy more often live-in with their employers. Hence, migrant workers more often have a personal relationship with their employer. There is no direct evidence that migrants are paid less than native employees. To the issue of job mobility I will come back below.

Let us now turn to employment conditions in the social care sector more generally. In the United Kingdom, social care was identified as one of the sectors where low pay is common. A large share of the workforce earns around the national minimum wage, some even less (Cangiano et al. 2009). It is a sector where shift work is common (table 4.9). In recent years, service provision has shifted from the public to the private sector, where employment conditions are generally worse than in the public sector. Wages are lower and social protection, including for example sick pay, is more limited (Land and Lewis 1998).

In the UK there is a big difference in the importance of migrant workers between agency-based elderly care and agency-based childcare. In the latter (nurseries), migrant workers are underrepresented. If we compare employment conditions between the two sectors, two things stand out. First, nursery nurses hardly ever have to do shift work (table 4.9). They often work part-time and they mostly work during normal office hours. Second, it seems that that nursery nurses have better career opportunities than care assistants (Interview Department of Families). Nursery nurses are relatively young, indicating that it is a starters' occupation. Later the employees move on to, for example, teaching in state funded schools. It could be that this job mobility makes the sector more attractive for native workers.

Compared to the UK, the social care workforce in the Netherlands is better paid and better protected. Compared to many countries, care workers in the Netherlands are more highly

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educated. 'In the Netherlands, there is a labour market based on professional standards and collective agreements' (Prismant 2009b: 51). Collective agreements guarantee minimum wages and employment conditions for all employees in the sector, irrespective of where they work. They also limit competition for employees among care providers. In the UK, such competition was seen as a problem:

> *One problem at present is the turnover of care workers chasing slightly higher wages being offered by another provider. They go round and round (Recruitment and retention officer cited in Department of Health 2007: 13).*

In general, working conditions and wages in the Dutch care sector do not seem to be worse than in comparable occupations in other sectors (ZIP 2009: 17). There are also more career options in long-term care in the Netherlands than in many other countries (Prismant 2009b). Because social care staff work at many different levels, people can begin as a 'helper' and end up as a trained care worker. Hence, in comparison with the UK, in the Dutch elderly care sector pay is better and there are more career options.

In the Netherlands, migrant workers are overrepresented especially among domestic workers. This group of workers lives-out more often than their Italian peers. However, the work within the private household completely lacks employment protection. By law, even regularly employed domestic workers are exempted from most social insurance schemes. In addition, the migrants working in the sector are often living in the Netherlands irregularly and, as a consequence, cannot access any employment rights.

In Italy, the private employment of elderly care workers fits with all the elements of the "bad" jobs mentioned above. There is, by definition, a personal relationship with the employer, and public controls of the employment relationship are limited. There is a special collective agreement for domestic and care workers (CCNL 2007), but this collective agreement includes less employment protection than what is common in other sectors. Care workers who live with their employer, in particular, work long hours and have limited free time (Iref 2007).

In conclusion, most of the expectations were again confirmed, but not all elements of working conditions seem equally important. One commonality is the fact that jobs in which migrant workers are overrepresented are always characterized by limited social protection. Elderly care on the market in the UK, private care work in Italy, and domestic work in the Netherlands, are all sectors in which employment protection and social insurance coverage are limited. Second, long working hours and a lot of shift work are other recurring factors that characterise the jobs in which migrant workers are overrepresented, especially in the UK and Italy. Another commonality is that all of the sectors in which migrant workers are overrepresented are characterised by low wages. However, there are also other low wage occupations, such as nursery nurse in the UK, in which migrant workers are scarce. Apparently,

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low pay is a necessary, but not a sufficient condition for the presence of migrant workers. Career options possibly make Dutch elderly care and British nurseries more attractive for native workers. Finally, a personal relationship with the employer is inevitable in private employment by families. In all countries migrant workers are overrepresented in such jobs.

6.3 Labour market regime and formal care work

Another expectation formulated in chapter 2 concerned labour market regimes:

A3 In a Liberal labour market regime are migrant workers are more likely to be overrepresented in formal care work

The expectation is based on the assumption that a formal market for care services can only exist in a country in which income inequality is high and employment protection is limited (i.e. a Liberal labour market, see the discussion in section 2.2, care work and labour market regimes). Jobs in such a formal market for care services are usually badly paid and hardly protected and, following expectation A1, migrant workers are likely to be overrepresented in these jobs. Table 6.2 presents some indicators of income inequality and employment protection in Europe and the US. At the top of the table it can be seen that the Netherlands, together with Denmark and Sweden, is characterised by low income inequality (a low Gini coefficient), low poverty rates, and relatively high employment protection. In Austria, France and Germany, income inequality and poverty are slightly higher, while employment protection is still strong. All these countries have characteristics associated with a Coordinated labour market regime.[84]

At the bottom of the table, the United Kingdom, the United States and Ireland are all characterised by high levels of income inequality and poverty[85] combined with low employment protection. These countries have a more Liberal labour market regime. In between these two extremes, we find Spain and Italy. In both countries income inequality and poverty are quite high, yet employment protection is also high. This is related to these countries' dual labour market. While 'insiders' who are in permanent employment are well protected, those who never had a permanent position lack employment protection or a minimum income guarantee (Saraceno 1994; Ferrera and Gualmini 2000).

[84] As was discussed in chapter 2, the term 'labour market regime' is used because I do not take the full set of characteristics included in a proper VoC approach into account. Liberal and Coordinated labour market regimes are assumed to be only one element of Liberal and Coordinated market economies.
[85] In the UK poverty rates were higher in the 1990s, but they have come down since.

Table 6.2: Income inequality, poverty rates and employment protection index in selected OECD countries

	Gini coefficient[1]	Poverty rate[2]	Employment protection index[3]	
			Late 1990s	2003
Netherlands	0.23	4.9	2.3	2.3
Denmark	0.23	5.6	1.8	1.8
Sweden	0.24	5.6	2.6	2.6
Austria	0.26	7.7	2.4	2.2
France	0.28	7.3	2.8	2.9
Germany	0.28	8.3	2.6	2.5
Italy	0.34	12.1	3.1	2.4
Spain	0.34	14.2	3.0	3.1
Ireland	0.31	16.2	1.2	1.3
UK	0.35	11.6	1.0	1.1
US	0.37	17.3	0.7	0.7

Sources: Employment protection index, OECD (2004: 117); Gini coefficient and poverty rate, LIS (2010). LIS data refer to 2005 for SE; to 2004 for the UK, the US, IT, DK; to 2000 for IE, ES, FR, DE, AT; and to 1999 for NL.

[1] Based on equivalent disposable household income.

[2] The percentage of households with an income below 50 percent of the median income.

[3] Scale from 0 to 6, higher number indicates stronger employment protection (see OECD 2004: Annex 2.A1 for further details).

In this study, the only country where substantial formal agency-based employment of migrant care workers was found is the United Kingdom. This is also the country with the most Liberal labour market of the three countries studied. In line with the expectations, in the Netherlands, the country with the most coordinated labour market, the employment of migrant workers in formal agency-based care is limited. So far, the patterns found in these two countries nicely fit with expectation A3.

Italy presents a bit of a puzzle with its high employment protection combined with high income inequality. The limited number of migrants employed in agency-based social care jobs might be a consequence of the strong employment protection, which inhibits the market provision of social services. Interestingly, however, in Italy many of the privately employed care workers are actually in regular, formal employment. They have an employment contract and pay social security contributions. Nevertheless, as we have seen before, their wages are low and they often work more hours than legally allowed. It seems that Italy has allowed the emergence of this grey area of formal and regular, yet badly protected employment. This situation is not unique to Italy. The Netherlands, too, has a special employment regime for domestic workers. These workers are not covered by most social insurances, they do not accrue

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old age pensions, and they are not entitled to the same leave arrangements that apply in many other sectors.

In sum, looking at labour market regimes seems to give an explanation for the high number of migrant workers in formal, agency-based social care in the UK. However, regarding the private employment of migrant workers, it is a less viable explanation. Both Italy and the Netherlands have allowed the emergence of a sector of private employment in which employment protection and social security coverage are more limited than in other labour market sectors. Within the otherwise Coordinated labour markets of Italy and the Netherlands, a segment has emerged that is more similar to a Liberal labour market regime, and is hence attractive for migrant workers.

6.4 Social care policies and care regimes

In chapter 2 a number of expectations were formulated regarding the effect of the organisation of social care on the employment of migrant workers. Since there are considerable differences in the organisation of child and elderly care in each of the case studies, below these two types of care are treated separately.

Elderly care

The first expectation to be evaluated here regards the effect of public expenditure:

A4 Public investments in social care crowd out demand for all types of migrant care work.

Table 6.3 presents figures on the public expenditure on elderly care services in Italy, the United Kingdom and the Netherlands. It should be noted immediately that the reliability of these OECD data has to be questioned. It is doubtful whether all expenditures are included. Some expenditures, such as the Dutch expenditures on home care, are missing altogether. In general, however, the figures seem to reflect the tendencies found in the case study chapters.

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Table 6.3: Public expenditure on different types of social care services for the elderly as percentage of GDP

		1990	1995	2000	2005
Netherlands	1. Institutions	0.53	0.50	0.66	0.87
United Kingdom	1. Institutions	...	...	0.25	0.32
	2. Home care	...	...	0.18	0.24
	Total 1 + 2	...	...	0.42	0.57
Italy	1. Institutions	0.07	0.05	0.06	0.05
	2. Home care	0,03	0,02	0,02	0,02
	Total 1+2	0,10	0,07	0,08	0,07
	Care allowance[1]	0.44	0.47	0.44	0.64

Source: OECD (2010b)
[1] For all disabled, not only the elderly.

The picture that emerges is that the Dutch state, even when expenditures on home care are excluded, spends most on elderly care services (see also the Dutch data presented in table 5.10). The UK spends considerably less than the Netherlands, but it still spends much more on home and institutional care than Italy. Italy's only large expenditure is on the attendance allowance.

There are very few migrants employed in the elderly care sector in the Netherlands, compared to many more in agency-based care in the UK and in private care in Italy. These aggregate data thus confirm expectation A4. Of course, this is a very simplified picture, which, among other things, does not tell us anything about the big differences in the employment of migrant workers between the UK and Italy.

Therefore, it is useful to have a more detailed look at how public policies organise elderly care in each of the countries. In the Netherlands, elderly care is organised through universal social insurance. Care services are an entitlement for everyone in need of long-term care. In 2005, 20.1 percent of all elderly received home care services through long-term care insurance, while 6.8 percent lived in a residential or nursing home (see table 5.1). When using OECD definitions the home care coverage rate is somewhat lower (see table 1.5), but nevertheless, in terms of coverage rates Dutch elderly care approximates the Social Democratic ideal-typical care regime (see discussion in chapter 2). However, services are not provided publicly but outsourced to mostly non-profit organisations. In addition, out-of-pocket contributions depend on a client's income and are relatively high. Finally, care recipients can choose to receive a personal budget instead of in-kind care services. With this personal budget recipients can choose to pay a family member for care services, adding an element of optional familialism (Leitner 2003) to the Dutch elderly care regime.

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England resembles a Liberal ideal-typical care regime to the extent that there is a market for social care services and public provision is means-tested. However, this means-tested public provision is relatively generous and every English citizen is entitled to use care services that are organised by local authorities[86]. In 2007-8, 5.8 percent of people aged over 65 received home care services organised by local authorities, and 3.3 percent lived in a residential or nursing home organised by local authorities (see table 4.1, as for the Netherlands, coverage rates are somewhat lower according to the OECD definition used in table 1.5). The generosity of the means-tested services gives the English system some Social Democratic traits. Care recipients can often choose to receive direct payments instead of in-kind care services and, as in the Netherlands, recipients have to justify how they spend these payments.

Finally, the Italian elderly care system closely resembles the Familialistic ideal type in many respects, although it should be noted that there are large regional differences. The Italian familialism is mostly implicit. Services provided on the market are scarce and expensive everywhere, while public provision is limited, highly means-tested and available only when the financial resources of family members are exhausted (Naldini 2003). In 2003, only 1.8 percent of all Italian elderly received publicly funded home care services, while only 2.1 percent lived in a publicly funded residential care facility or nursing home (see table 1.5). The only universal benefit available for everyone in need of care is an attendance allowance, which in 2007 was paid to 9.8 percent of all Italian elderly. According to the OECD data in table 6.3, the Italian state spends nine times more on this cash benefit than on residential or home care services.

Care regimes and the use of agency based and private care services

In the Netherlands, high public investments make elderly care services available for most people in need (SCP 2007d: 101). Moreover, both low and high income groups can benefit from the Dutch system. Waiting lists for care services have been a recurring problem, but in response public provision has been expanded, especially in the late 1990s. Only 3 percent of all Dutch people aged 80 or over live together with one of their children (see Appendix table A-1), but this does not mean that informal unpaid care is not important. Of all Dutch dependent elderly (aged 50+), 50 percent received some kind of informal care in 2004, compared to 58 percent in Italy (see SHARE data presented in Appendix table A-2). However, compared to Italy, the provided unpaid care is less intensive. Only 17 percent received care on a daily base, compared to 44 percent of all Italian informal care recipients. Moreover, most unpaid care consists of administrative help (20 percent) or home help (65 percent), and less of personal care (16 percent

[86] Local authorities organise the care service, but well-off citizens have to pay for the full costs.

in the Netherlands compared to 44 percent in Italy). Family care is often provided by women who are also part-time in paid employment (SCP 2010). The widespread availability of publicly funded services has at least partly crowded out the demand for privately purchased services. Private care homes exist, but they are not very common. More common is privately purchased home care. The available data suggest, however, that this is mostly limited to home help (cleaning) and does not frequently involve personal care (SCP 2007c). Individuals dependent on personal care rely heavily on the public system.

In England, publicly funded social care services are highly means-tested and used mainly by care users with a lower income. In theory, everyone has the right to demand from the local authorities that their care be organised for them (but those with a high income or assets then have to refund the full care costs). In practice, many well-off elderly organise their own care. Compared to the Netherlands, the private market for residential care is much more developed. Estimates suggest that a quarter of all care home places are privately funded, and a fifth of home care is privately purchased (Poole 2006: 5). Unfortunately, the SHARE data on informal care (Appendix table A-2) are not available for the United Kingdom. Informal unpaid care is certainly important in England (see for example Bettio and Plantenga 2004), but similar to the Dutch case, family care is less intensive than in Italy (see also the discussion in section 4.3).

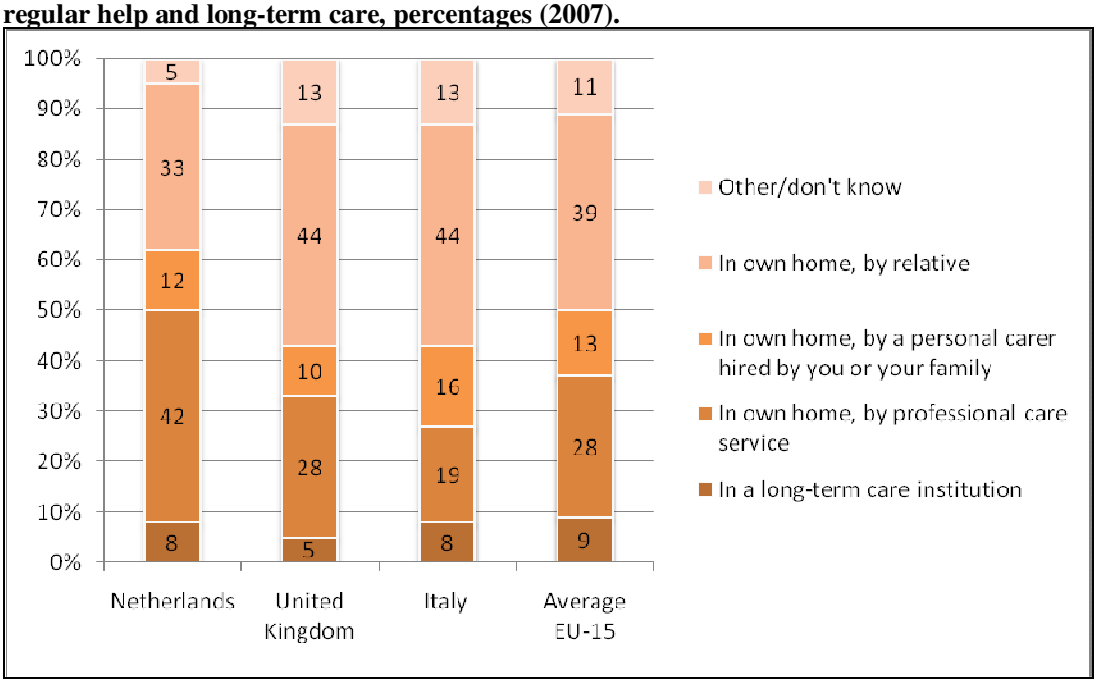
In Italy, with its limited and highly means-tested public provision, the family is more central in care provision than in the Netherlands and in England. Of all people aged 80 and over, 42 percent lived together with a child (see Appendix table A-1) and informal care is often provided on a daily base, involving intensive personal care (Appendix table A-2). With the rapid population ageing and increasing female employment rates, the ability and willingness of families to cover all care needs has decreased. In the absence of public provision, and with services on the formal agency-based market being prohibitively expensive (Mensini and Gambino 2006: 59), Italian families have started to rely in large numbers on private care services predominantly provided by migrant workers.

The use of different types of public and private, agency and family-based services largely fits with the constraints set by public policies. In the largely Social Democratic Dutch elderly care regime, most elderly rely on publicly funded care services. In the English care regime, which is a mixture of Liberal and Social Democratic traits, many elderly also rely on publicly funded services, but a larger segment than the Dutch elderly buys services privately on the market. In the Italian highly Familialistic care regime, families have privately employed migrant care workers.

There are, however, some patterns that cannot be explained just by care policies. For example, both the English and Dutch better-off elderly can afford to hire a private (migrant) care worker, which might be even more affordable than the formal services they use instead. After all, Dutch well-off elderly pay a large out-of-pocket contribution for public services, amounting to up to 1800 Euros a month, while English well-off elderly do not receive any public support. Why do they nevertheless only infrequently rely on private migrant care?

Figure 6.1 shows that in a Eurobarometer survey only 10 percent of British and 12 percent of Dutch survey respondents see care by a private personal carer as an ideal solution when one becomes dependent on long-term care. Interestingly, this percentage is only slightly higher in Italy (16 percent). The three countries are also similar in the extent to which respondents dislike residential care. Only 8 percent of Italian and Dutch, and only 5 percent of British respondents reports residence in a long-term care institution as the preferred solution. There is more variation to be found in the preference for care by relatives and care provided by professional care services. While the latter is clearly preferred in the Netherlands (42 percent), the former is the favourite option of Italians (44 percent), while respondents in the UK like both professional care services (28 percent) and care by relatives (44 percent).

Figure 6.1: Preferred way to be looked after when one becomes dependent and needs regular help and long-term care, percentages (2007).



Source: Eurobarometer (2007: 97), see also Appendix table A-4

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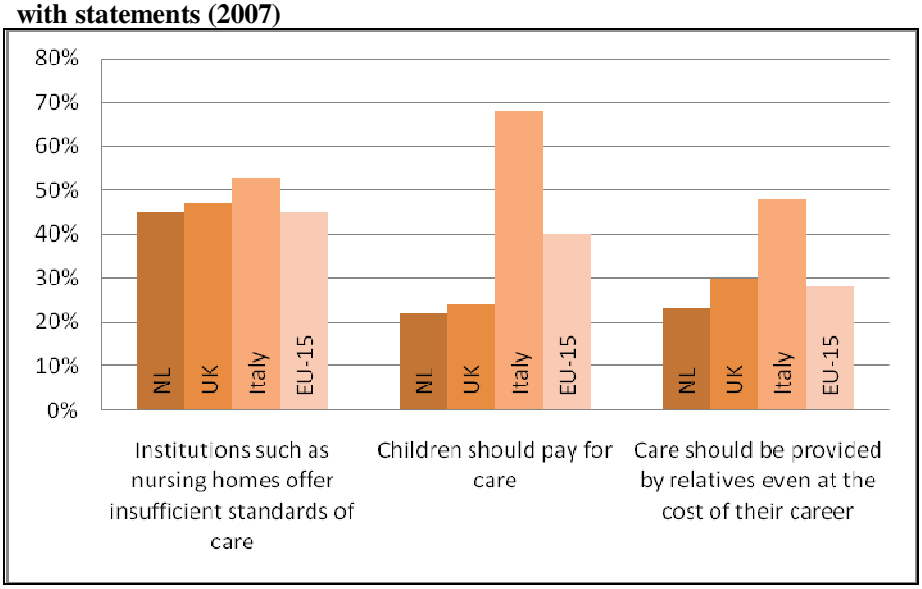
Figure 6.2 confirms that the cross-national difference in the number of respondents believing that long-term care institutions are undesirable (offering insufficient standards of care) is not very large. Much bigger are the differences with regard to the expected role of relatives. The percentage of Italian respondents agreeing with the statement that children should pay for care is three times higher (68 percent) than in the Netherlands (22 percent) or in the United Kingdom (24 percent). Similarly, many more respondents in Italy find that relatives should provide care even if it is at the cost of their career than in the Netherlands and the United Kingdom.

Figure 6.2: Percentage of respondents agreeing and totally agreeing with statements (2007)



Source: Eurobarometer (2007: 76 and Appendix), see also Appendix table A-4

The Italian 'migrant in the family' model of care involves a large input from family members, who organise and continuously monitor the situation (Da Roit 2007). The opinion data that were just discussed, together with cohabitation patterns of older people with their children and the reliance on informal unpaid care (Appendix table A-1 and A-2) suggest that in Italy this involvement of family members is relatively normal and generally expected. By contrast, especially in the Netherlands and to a lesser extent in the UK, older people live more independently from their children. Informal family care is important, but it more often involves less intensive support with administrative tasks and home help. By contrast, family involvement to the extent that family members pay for care or even give up their career to provide care, is not as normal as it is in Italy. The migrant in the family model of care does not fit with this greater independence of older people.

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How the state shapes employment conditions in different forms of care

We have seen that in the Netherlands most care services are provided by publicly financed providers. In this country, labour market shortages are an important concern for both the state and the care providing agencies. Consecutive governments have invested in training opportunities for care workers and in better employment conditions[87]. Meanwhile, collective agreements guarantee similar working conditions for all providers, which prevents competition among these providers.

In England, there are large differences in pay and employment conditions between the public and the private sector. Local authorities, employing only a small part of the total social care labour force, offered better pay and employment conditions than private providers (Land and Lewis 1998: 63; Cangiano et al. 2009). Just as occurs in the Netherlands, the social care workforce is currently an important concern for the British government and there is considerable attention given to training and recruitment of these workers (Department of Health 2007: 41). Nevertheless, the private sector has encountered major problems with the recruitment and retention of workers. For example, in 2005 average turnover rates in home care were 26 percent (Department of Health 2007: 33), compared to only 12 percent in the Netherlands[88] (Prismant 2009b: 35). The reason for the continuous problems associated with recruiting and retaining workers is that the public attention has not addressed the fundamental problem of the social care sector, namely that funding is insufficient to offer decent wages and good employment conditions (see chapter 4, section 4.3). This should, however, not be exaggerated either. Although migrant workers were important in the formal elderly care sector, the great majority of employees in the sector are still native British. Perhaps the efforts of the British state have had some effect in making social care still an acceptable job for many native workers.

In Italy, the state has rarely had a direct influence on the employment conditions of private care workers. Trade unions negotiated a collective agreement which guarantees regularly employed care workers minimum pay and social protection. In addition, some regions have encouraged households to employ their migrant care workers regularly through cash benefits. In general, however, the employment conditions in the private care sector are determined by families, by the money they are prepared to pay, and by the numbers of hours of work they expect in return.

[87] See for example: Arbeidsmarktbrief 2008, Minister van VWS, MEVA/ABA-2900709 and Actiz, arbeidsmarkt zorg.
[88] In fact the turnover rate in the Dutch home care sector increased sharply after the introduction of the new Social Support Act, which will be further discussed below.

Cash for care arrangements

Chapter 2 paid attention specifically to the impact of cash for care benefits on migrant care work:

> *A5 Cash allowances, especially when unregulated, lead to a demand for migrant care workers employed privately and informally.*

The Netherlands, Italy and England each have their own cash for care schemes, therefore this case comparison is an excellent opportunity for comparing their impacts. Italy's attendance allowance (Indennità di Accompagnamento, IA) is paid at a flat rate to people in need of long-term care. It is needs but not means-tested. Its take-up is high, with around 10 percent of Italian elderly receiving the allowance. Spending is entirely uncontrolled, meaning that the person receiving the benefit is completely free to decide how to use it. It can be used to supplement household income, to pay a friend or family member, or to hire a private care worker.

The Dutch Personal Budget (Persoonsgebonden Budget, PB) has also become popular, with around 10 percent of long-term care recipients choosing to receive their care in cash. Spending through the budget is controlled, meaning that the budget user has to keep track of what the money is used for. Family members can be hired, and this is in practice often done. Alternatively, services can be bought on the market. The height of the personal budget depends on the client's care needs and the client's own income.

Table 6.4: Some characteristics of cash for care schemes available for older people in Italy, the Netherlands and England.

Country	Name arrangement	Generosity	Means tested?	Applicability/ Remarks	Use regulated?
Italy	Attendance Allowance (IA)	€465,09 / month	No	For severely disabled, all ages	No
NL	Personal Budget (PB)	Up to 100% of total costs (Same as costs of formal services, minus 15-20%)	Partly		Yes
England	Direct Payment Scheme (DP)	£9.75 / hour	Yes	Disabled (18+)	Yes
	Attendance Allowance (AA)	Between £170 and £255 / month	No	Older people (65+)	No

Sources: OECD (2005), European Commission (2006), EUROFAMCARE (2004).

The English Attendance Allowance (AA) is paid to every older person in need of long-term care. The AA is very similar to the Italian IA, but less generous. It can be freely used and spent according to the recipient's preference. In addition there is the Direct Payment (DP), which is

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similar to the Dutch PB, but it is completely means-tested. Its take-up is much lower than the Dutch scheme, but it has been growing in recent years. Spending through the DP scheme is controlled and paying family members is not allowed.

In Italy, the IA 'is important to account for the fact that even relatively low income families can afford to buy the services of migrants.' (Bettio et al. 2006: 272). With migrant care assistants being paid something between 700 and 900 Euros a month, the 465 Euros of the IA forms an important contribution towards these costs. According to survey data discussed in chapter 3, only around 1 percent of all elderly employ a live-in migrant care worker. Though this figure is probably an underestimation[89], it is striking that in a survey of recipients of the IA, Ranci and Pavolini found that 27 percent of them lived with a paid carer (Ranci and Pavolini 2008). The Italian *Indennità di accompagnamento* clearly contributes to the widespread employment of private foreign care assistants.

In the English and Dutch cases, research on the use of Direct Payments and Personal Budgets has shown that in both countries it these schemes are mostly used to pay care workers who had previously worked for a care providing agency (or family members in the Dutch case) (Kremer 2006; IFF Research 2008). There is no evidence that the budgets have induced a demand for migrant workers. In fact, in both countries the care assistants employed through the cash for care schemes reported to enjoy the greater freedom and flexibility of the private arrangement (ibid.).

What remains puzzling in a comparative perspective is the English Attendance Allowance (AA), which is, just as the Italian IA, not means-tested and paid to a very large group of elderly (19.3 percent of all those aged over 65 in 2002/3, according to OECD 2005). The amount paid through the AA is between £170 and £255. There is no evidence that the AA would be fuelling the employment of (migrant) care assistants. In a recent research project on the impact of the AA it was found that the allowance is generally used to relieve financial pressure, to pay for transport, food, fuel, or to pay for gifts for relatives and friends who helped out. For personal care needs, the AA recipients 'relied on adult children, professional care services, and local people paid for help' (Corden et al. 2010: 56). Hence, the AA seems to be used for general purposes, and for paying a friend or neighbour for some help, but is not commonly used for providing a private care assistant.

In sum, it seems to be important for the impact of cash for care payments whether their use is controlled or not. Because the spending through the Dutch Personal Budget and the English Direct Payment scheme is controlled, these have not given care users an opportunity or

[89] People might be reluctant to report hiring a migrant care worker who is working irregularly. Moreover, those mostly in need of care might not be able to participate in a survey.

an incentive to buy care services on the informal market. The Italian uncontrolled attendance allowance (IA), on the other hand, clearly supported the employment of (informal) private care assistants. However, the English uncontrolled AA does not fit into this picture. The amount paid it is probably too low to make a difference. But this finding also reinforces the importance of looking at care regimes as a complete package. Within the Italian Familialistic care regime, the IA allows even middle class families to hire a private care assistant. Within the more Liberal English care regime, the AA does not change the general pattern of the less well-off relying – in addition to family support – on public services, and the better-off relying on agency based or private formal care.

In conclusion, the cases of migrant employment in elderly care in the Netherlands, Italy and England point at an influence of 'care regimes' as a package (expectation A6). In the Netherlands, with its care regime that comprises strong Social Democratic characteristics, a combination of extensive public provision and a preference for professional services resulted in a limited demand for agency-based and private migrant care workers. In Italy, with its highly Familialistic care regime, a demand for migrant workers emerged due to the lack of public provision. In line with the expectation that family members should contribute to care arrangements, a 'migrant in the family' model of care emerged. The English care system, a mixture of Liberal and Social Democratic traits, created a moderate demand for migrant workers in agency-based employment. To distinguish this type of migrant employment from the Italian 'migrant in the family' model of care, the English situation could be called a 'migrant in the market' model of employment.

Childcare

The cross-country differences in the employment of migrant workers in childcare are much less pronounced than those in elderly care. In general, migrant workers were found to be less important in the childcare sector. In none of the countries do they play a significant role in agency-based employment, yet in each of the countries there is some evidence of migrants being employed privately by families. This seems to be most widespread in the UK, followed by Italy and then the Netherlands (see table 6.1), but there are no comparable data available so this should be seen as an educated guess.

The OECD provides data (OECD 2010b) on public expenditure on childcare, but their reliability has to be questioned. These data, for example, do not include the child care tax credits, which are the backbone of the Dutch childcare system, and which are very important in the United Kingdom too. In 2005, according to the OECD, the UK spent 0.4 percent of GDP on

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childcare services and 0.2 percent on pre-primary education. In Italy these figures were 0.2 and 0.5 percent respectively, and in the Netherlands 0.1 and 0.4 percent. If we take the spending through tax credits and the recent expansion of Dutch public investments in childcare into consideration, these figures should be somewhat higher for the Netherlands. On average, OECD countries spent 0.6 percent of GDP on childcare services and pre-primary education together. Hence, the three countries considered here do not deviate substantially from this average, at least not based on the 2005 data.

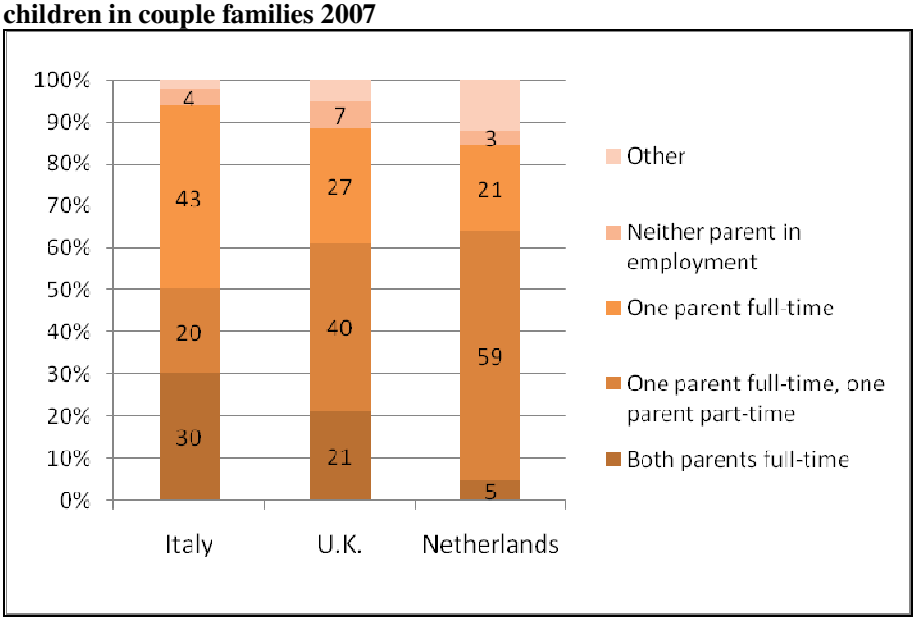
In relation to expectation A4 regarding the impact of public investments on the demand for migrant care work, the variation in public expenditure on childcare in Italy, the Netherlands and the UK is too small to draw any conclusions. Let us therefore have a closer look at the organisation of childcare in the three countries. Until the 1990s, care for young children was largely a family affair in all three of the cases. Only Italy stood out with its universal public pre-school system for 3 to 5 year olds. Apart from that, all three countries closely resembled the Familialistic ideal-typical care regime, with both market and public provision being hardly developed. This situation changed in the 1990s, when public investments in childcare were strongly expanded in both the Netherlands and the UK. Especially in the Netherlands this coincided with a strong increase in women's employment rate.

In the Netherlands the expansion of childcare services at first took place through large subsidies paid to childcare providers by local governments. In 2005, this system was replaced by a cash subsidy paid directly to families through tax credits. Parents have to use this subsidy to buy formal childcare services on the market. The UK's Labour government, taking office in 1997, introduced a similar cash subsidy for parents paid through tax-credits, supplemented by investments in local community childcare centres. In one respect the British and Dutch systems differ. Public services and cash allowances in the UK are mostly targeted at poor families, while those in the Netherlands are very generous also for middle class parents. In Italy, finally, there have been no significant changes in the organisation of childcare for young children recently.

Characterising care arrangements in the three case studies in terms of ideal types is difficult. In each country, the family – parents (mostly mothers) and grandparents (mostly grandmothers) – has continued to play a central role in caring for young children. As can be seen in figure 6.3, relatively many Italian children (43 percent) live with one parent in full employment and the other staying at home. In the UK and especially in the Netherlands, children more often live in a household in which one parent works full-time and the other part-time (respectively 40 and 59 percent). The care arrangements in each of the three countries still have some Familialistic traits. Meanwhile, the Italian pre-school system is Social Democratic in its design. The generosity of the Dutch cash subsidies for childcare for all income groups also

lends this system some Social Democratic characteristics. However, in the Netherlands the cash allowances have strongly encouraged a more Liberal childcare market. Finally, the means-tested nature of English public childcare means that it most closely resembles the Liberal ideal type. Yet as with elderly care services, the means-tested benefits are more generous than what fits with an ideal-typical Liberal care regime.

Figure 6.3: Children aged 0 – 14 by parental employment status, only children in couple families 2007



Source: OECD (2011a)

The pattern of employment of migrant workers in childcare that was found, raises a number of questions. First, why are migrants more often employed in private care than in agency-based care in each of the countries? Second, why are private migrant care workers most common in the UK? And finally, why are private migrant care workers more common in childcare than in elderly care in the Netherlands and the UK, yet much more common in elderly care than in childcare in Italy?

Let us first turn to the lack of employment of migrant workers in agency-based childcare services. As in the elderly care sector, the Dutch childcare sector has its own collective agreement, guaranteeing minimum wages and employment conditions for all employees in the sector. However, the large growth of the childcare sector in recent years placed the childcare sector under pressure. To cope with the increasing labour force needs, many providers employed temporary workers. In 2009, 26 percent of the workers had a temporary contract, compared to only 13 percent in the elderly care sector (Prismant 2009b: 27). In the meantime, the number of enrolments in professional childcare education has increased

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(ibid.: 28) and the sector has managed to attract many new employees who were previously unemployed (ibid.: 44). Turnover rates were not very high, ranging from 10 to 13 percent between 2004 and 2008 (ibid.: 35). It seems that the childcare sector has adequately responded to the strong increase in childcare workers.

In the UK, nursery nurses earned less than care assistants, making it among the lowest paid professions in the UK (Daycare Trust 2008: 2). That migrant workers are nevertheless underrepresented is probably – as was discussed in chapter 4 – related to the fact that nursery nurses work fewer hours and (night) shifts than the care assistants employed in elderly care (see table (see table 4.9). Meanwhile training a childcare workforce has been an important concern of the British government. While the government is concerned about the number of childcare workers that leave the sector to move on to other jobs (Interview Department of Families), this might also be an advantage. The opportunity to progress to jobs in the educational sector might make the childcare sector more attractive for people entering the labour market.

The second question centres on why private migrant care workers (nannies and childminders) are most common in the UK, followed by Italy and then the Netherlands. This cross-country difference fits with differences in public provision in the three countries. In England, public provision and subsidies are only available for low-income families. The better-off have to provide for their own services. These better-off families often rely on nannies and child-minders (table 4.2), who are in turn more often foreign than employees in nursery nurses (table 4.3). In Italy, almost all children aged 3 to 5 attend pre-schools. This leaves only the 0 to 2 year olds to be cared for privately. Compared to the UK and the Netherlands, care for this group is more often provided by the mother (or a grandparent). Yet for couples that are both working full-time, which occurs more often than in the Netherlands and the UK (see figure 6.3), the private (foreign) nanny is an alternative (see table 3.10 and the discussion in chapter 3). In the Netherlands, compared to the UK, childcare subsidies are available for a much larger group. Hence, even parents with a high income can still get part of their childcare expenditures refunded provided that they buy childcare services on the formal market. In addition, many parents combine part-time working with part-time care arrangements. There is, consequently, less of an incentive to rely on (informal) nannies and childminders.

Finally, how can we explain the differences in the importance of private migrant care workers between child and elderly care? For the British and Dutch cases there could be a cultural explanation. Contrary to elderly care, both countries have a history of private family care. Until quite recently, mothers were expected to stay at home and care for their children (see e.g. Lewis 1992). A ‘mother substitute’ form of care is still valued in these countries (SCP

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2007b; Vincent et al. 2008; Williams and Gavanas 2008). This has had a particular influence on the English situation, where well-off families have to arrange their own care provision.

There are several factors that could explain why in Italy migrant workers are more important in elderly care than in childcare. First, with the availability of universal pre-school facilities, public provision for children is more extensive than for dependent elderly and as a consequence, less additional care services are required for this group. Second, there is an important difference in the nature of child and elderly care services. While Italian families often look for full-time, 24 hours-a-day care for older people, care for children is usually sought only for the periods during which parents are at work. Similar to agency based child and elderly care in the UK, employment in elderly care involves more (night-)shift work. It is this kind of work with long and irregular working hours that is undesired by native workers and therefore filled by migrant employees (see section 6.2 of this chapter).

In conclusion, the relationship between care systems and the employment of migrant workers (expectation A6) is not as straightforward in childcare as it was found to be in elderly care. The reason for this is the sub-optimal selection of cases which gave only a limited variation in the organisation of care. Nevertheless some impact for care regimes seems to exist. In the Dutch system, public subsidies covered all income groups, thereby encouraging all these groups to rely on formal services. The public pre-school system in Italy probably crowded out some of the demand for private care workers. In the UK, on the other hand, high-income families had to arrange their own care and often opted for private (foreign) nannies. The preference for (foreign) nannies instead of day care centres in the UK seems to be related to the cultural legacy of a Familialistic care regime and the preference for a 'mother substitute' type of care. Finally, the fact that care for dependent elderly in both agency-based and private settings often involves more night and shift work than childcare probably contributes to the more limited importance of migrant workers in childcare.

6.5 The impact of immigration policies

The previous section focused on how social care policies and care regimes shape the demand for migrant care workers. The impact of immigration policy has not yet been taken into consideration. Regarding the impact of immigration policies, three expectations were formulated in chapter 2. The first concerns the impact of expansive labour migration policies:

A7 Expansive immigration policies for migrant care workers encourage their employment.

Table 6.5 summarises the policies that regulate immigration in the social care sector. While migrant workers from the countries that entered the EU in 2004 (the A8) could work without

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any restrictions in each of the three country case studies, there is much more variation in the policies applying to citizens of Romania and Bulgaria (the A2) and third-country nationals. Regarding these latter two groups, Italian policies have been much more expansive for migrant care workers than British and Dutch policies. Since Italy is also the country where we found most migrant care workers to be employed, the question becomes to what extent the presence of migrant care workers can be explained by the immigration policies that regulate their inflows.

Table 6.5: Immigration regulations related to migrant care workers from different origins

Country of destination	Type of care work	Region of origin: A8[1]	A2[2]	Third-countries
Italy	Elderly care	Yes, general (since 2007)	Yes, specific (since 2007)	Quotas (since 2005) and regularisations (2002 and 2009)
	Childcare			
UK	Elderly care	Yes, general (since 2004)	No exceptions, made more difficult (in 2007)	No exceptions, made more difficult (in 2007)
	Childcare		No exceptions	No exceptions
NL	Elderly care	Yes, general (since 2007)	No exceptions, rarely possible	No exceptions, rarely possible
	Childcare		No exceptions	No exceptions

[1] The ten countries that joined the EU in 2004, minus Cyprus and Malta. A8 = Poland, Estonia, Latvia, Lithuania, Hungary, Czech Republic, Slovakia, Slovenia.
[2] The two countries that joined the EU in 2007: Romania and Bulgaria

Labour migration policies that specifically address migrant care workers impact directly on the regular employment of migrant workers in certain sectors. Examples include the British work permits for 'senior care workers', which allowed many Filipinos, in particular, to work in the sector (Cangiano et al. 2009), and also the freedom granted to Romanians and Bulgarians to work as private care assistants in Italy. There is, however, no direct causal relation between the expansiveness of labour migration policies and the number of migrant workers. For example, A8 workers are free to work in all three countries, yet they are not particularly overrepresented in most care sectors. While many A8 citizens moved to Britain for work, relatively few of them took up employment in elderly care. The employment of A8 nationals was only substantial among childminders. The Netherlands also witnessed a substantial inflow of A8 nationals in 2007. However, again these were not often employed in care services. On the contrary,

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according to a public official, they were employed everywhere but in the social care sector. (Interview Ministry of Justice).

One factor that reduces the impact of labour migration policies is the fact that only a small share of migrant workers rely on work permits, especially in the UK and the Netherlands. In the UK, for example, Cangiano et al. found that only 19 percent of all recent immigrants working in social care were dependent on a work permit (Cangiano et al. 2009). The rest came to the UK as refugees, students, or had indefinite leave to remain, for example, as a consequence of family reunification. In the Netherlands, the few organisations in Amsterdam that reported hiring migrant workers, also pointed out that most of these had come to the Netherlands as asylum seekers or as family members. Among the five care providers in Amsterdam that were interviewed for this research project, only one respondent named the limited availability of work permits as a reason not to employ migrant workers. Instead, recent immigrants employed in the social care sector often came to the Netherlands as refugees or through family reunification.

In Italy, the employment of migrant care workers started well before expansive immigration policies for domestic and care workers were enacted. The first policy that specifically targeted this group of workers was the regularisation included in the 2002 Bossi-Fini Act. Through this regularisation, 316,000 domestic and care workers were regularised. All of these migrant workers had already been working in Italy for a certain period of time. The large presence of irregular migrants in Italy forms a continuous pool of potential labour.

That labour migration policies do not directly cause immigration does not mean that they are not important. The expansive immigration policies in Italy have allowed many migrant domestic and care workers to be regularly employed. In the Netherlands, on the other hand, no work permit is available for migrant workers employed by private households. As a consequence many of these work irregularly. This finding is in line with expectation A8:

A8 Restrictive immigration policies push immigrants into informal private employment.

An interesting case is the recent restriction of eligibility criteria for senior care workers in the UK. Since a demand for migrant workers was clearly visible in the elderly care sector in England, the restriction forms a test case for the impact of labour migration policies. It could be that more irregular immigrants are employed, or that a shift takes place from, for example, Filipino migrants who were dependent on a work permit, to Zimbabwean migrants who have leave to remain as refugees. Unfortunately it is too early to understand the consequences if these restrictions

For now, it can to be concluded that there is no evidence that labour migration policies directly impact on the number of migrant workers in caring occupations. They do, however,

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shape the circumstances under which migrant workers are employed. Restrictive immigration policies hinder formal agency-based employment and encourage more irregular employment.

The last expectation formulated in chapter 2 concerned the attractiveness of migrant workers for employers:

> *A8 The vulnerability of immigrants that are irregularly present or dependent on a work permit could make these migrant workers more attractive for employers.*

Evidence supporting this claim was found in both the British and the Italian case studies. In Italy, in September 2009, only 114,336 families applied for the regularisation of their care assistant[90], a number that was lower than what was expected based on estimates of the number of irregular migrant workers that were actually employed. The reasons given for the limited enthusiasm among Italians to regularise their domestic worker included the high costs of applying for regularisation. In addition, social security contributions had to be paid both for the months in which the employment relationship had existed irregularly, and for the future duration of employment. Together these two factors substantially increased the costs of hiring a migrant care worker. The higher costs of regular employment is confirmed by an Italian survey of domestic workers, which found that those with a regular status earned higher wages while working fewer hours than those irregularly present (Iref 2007: 36).

It is not just high costs that make migrant workers less attractive. Migrant workers who are regularly employed can also go to court to enforce their rights, for example to ensure their access to free time or holidays. In chapter 3 it was suggested that regular migrants would abuse this option, by suing their employer even when the employer had done nothing wrong. Whether this is true or not, it is clear that regular migrant workers have a more powerful position vis-à-vis their employer than irregular workers. In relation to this, an official at the Italian ministry suggested that since Romanians are free to work in domestic and care work in Italy, they have become less popular (Interview Ministry of Labour – 3), precisely because they are free to come and go, or to start working for another employer.

In Britain, employers in the social care sector actually preferred to hire a migrant worker dependent on a work permit because they were more eager to stay in the job (Cangiano et al. 2009). As a consequence, they were more likely to accept poor employment conditions and longer working hours. Workers from the new EU member states, on the other hand, were more likely to move out of the job quickly, because they were free to opt 'for an easier life working for Tesco'[91].

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[90] Ministero dell'Interno, Dichiarazione di Emersione, Dati Devinitivi: 01-10-2009.
[91] Immigration Matters – The Care Industry still needs migrant workers, August 2006, http://www.immigrationmatters.co.uk/the-care-industry-still-needs-foreign-workers.html.

To conclude, in as far as information is available, the expectation of the attractiveness of vulnerable migrants is confirmed. Some employers have a preference for migrant workers who are dependent on a work permit, or who are completely irregular, because these workers are more likely to accept unpleasant working conditions.

6.6 Economic circumstances, crisis, and the flexibility of demand for migrant labour

One last expectation that still needs to be discussed concerns the flexibility of demand for migrant care workers:

A2 Demand for migrant labour increases in times of economic boom, when native workers have the opportunity to move up, and decreases in times of economic downturn.

Other scholars discussed in chapter 2 maintain that once migrant workers have started to work in a certain sector, then social labelling or other unintended consequences of immigration lead to a permanent demand for migrant labour in that sector.

To investigate these claims, we can look at the impact of economic upturns and downturns on the demand for migrant care workers in each of our cases. In the Netherlands the economic boom and general labour market shortages of the late 1990s put the social care sector under substantial pressure. In direct response to these shortages, experiments were initiated to attract migrant nurses and carers. In the meantime, the government also invested significantly in employment conditions and training in the social care sector. When economic growth slowed down in the early 2000s, this also meant a relief of staff shortages for the social care sector. In 2008, when the worldwide financial crisis started, job mobility centres were set up to facilitate a move of redundant personnel from the profit sector to the care sector. In the short run, the crisis seems to have resolved many of the recruitment problems of the social care sector (Prismant 2009a: 37). Due to the limited availability of data on migrant workers in the sector, it is impossible to say whether the number of migrant workers employed in the sector also increased in times of economic upturn and decreased in times of economic downturn. However, the expectation above is confirmed with respect to the general staff shortages.

Similarly, in the UK it seems that the 2008 economic crisis has relieved the acute workforce problems for care providers. The number of unfilled vacancies fell in early 2009 and employers reported that more native British people were applying for jobs. However, they also doubt whether the applicants were suitable for work in the social care sector (Cangiano et al. 2009). Nevertheless, it seems that the acute demand for migrant workers has decreased.

In Italy, little is known about the impact of the crisis on the employment of migrant care workers, but anecdotal evidence also points to a decrease – or slowing growth – in the employment of migrant workers. Local newspapers have suggested that the demand for

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(regularly employed) care assistants was decreasing[92]. In addition, they suggest that the number of Italian women trying to find work as private care assistants is increasing[93]. The latter is a particularly striking development. The occupation of private care assistant ('badante') is perceived to be a job completely confined to migrant workers. As such, it could be expected that social labelling would ensure that the job continues to be a job for migrants only. However, anecdotal evidence suggests that this is not the case. The crisis would have pushed Italian women into this occupation, just as the expectation above suggested. However, all this concerns only the employment of care assistants. It is conceivable that the decreasing demand on the formal market is offset by an increasing demand for cheaper informal work. The crisis could, perhaps, induce a further bifurcation of the sector between regularly employed live-out Italian care assistants, and irregularly employed live-in migrant workers.

In conclusion, the economic crisis has attenuated immediate staff shortages in social care in the UK and the Netherlands. This tendency was probably accompanied by a smaller demand for migrant workers. Even in Italy, where care assistance has become a job largely filled with migrant workers, there is some evidence that the crisis has encouraged more Italians to seek employment in this sector. Whether this applies to the whole sector, or only to some of the better paid regular live-out jobs, remains questionable. In general, the limited evidence available supports the expectation that economic circumstances affect the demand for migrant workers, even in Italy, where the social labelling of care assistance jobs as migrants' jobs is strong.

6.7 Conclusion

In this chapter, explanations for the employment (or the absence) of migrant care workers were systematically compared. Cross-country commonalities were found in the conditions under which migrant care workers are employed in the United Kingdom and Italy. Although migrant workers work in very different settings, they all work on average longer hours than their native peers. They work night-shifts much more often (in England), or are more likely to live with their employer. Their wages are low, but not necessarily lower than the wages earned by their native peers. In comparison with the Netherlands, elderly care workers in both Italy and the UK lack social protection and have limited opportunities for training and career development.

[92] *La Repubblica*, 'Effetto crisi su colf e badanti. In un anno contratti dimezzati', 29/05/2010.
[93] *Corriere Del Veneto*, 'Corsi per badanti, boom di italiane', 19/12/09; ' Crisi: a Bologna tornano le badanti Italiane, sono almeno 700', www.dire.it, 05/06/2010.

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Formal agency-based employment was found to be more common in the more Liberal labour market of the United Kingdom than in the more coordinated Italian and Dutch labour markets. However, these Coordinated labour market regimes did not prevent the (regular) employment of (migrant) workers in private care. Both Italy and the Netherlands have allowed the emergence of a sector of private employment with only limited employment protection and social security coverage.

When trying to explain the differential importance of migrant workers in elderly care in the three countries, there is a clear impact of public investments on the employment of migrant workers. In the Dutch elderly care sector, these public investments guarantee the availability of care services for most elderly in need of care. They also contribute to the maintenance of decent wages and acceptable employment conditions for employees in the social care sector, because the state invests in training and recruitment of sufficiently skilled staff.

In England, public investments are less generous and publicly financed services are means-tested. As a consequence, many English elderly have to buy their services on the private market. Moreover, the limited public investments force care providers to provide care at low costs. As a consequence, the providers need employees that are willing to work long hours and do shift work for low pay. The sector has had great difficulties finding native workers who were prepared to work under these conditions. Therefore, migrant workers were attracted instead.

In Italy, public investments in elderly care are even less generous than in England, except for a widespread attendance allowance. With the near absence of public provision, and the formal market being too expensive for most, families employed migrant workers privately. The attendance allowance ensured that many families could afford to hire a private care worker.

This brings us to the importance of cash for care schemes. A comparison of the different cash for care schemes suggested that their impact depends on the extent to which spending is controlled. The English and Dutch controlled cash budgets did not encourage the private employment of migrant workers. However, in England there is also an uncontrolled attendance allowance very similar to the Italian one. Yet there is no evidence that this allowance contributed to the employment of migrant care workers. This finding suggests that the impact of a cash for care scheme can only be understood within the context of the overall care system.

The different developments in elderly care in Italy, the Netherlands and England suggests that there is a relationship between the prevalent care regimes and the employment of migrant care workers. The three different ideal types of care regimes that were formulated in chapter 2, seem to give rise to different types of employment of migrant workers:

- In a *Social Democratic* care regime (approximated by elderly care in the Netherlands), care services are publicly provided without a means-test. Because care is publicly funded, the state is also directly responsible for setting the employment conditions in

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agency-based care. Due to public investments, no demand for migrant workers emerges in the agency-based care sector. Moreover, the availability of publicly financed care services crowds out the demand for (informal) private care.

- In a *Liberal* care regime (of which elderly care in England shows some characteristics), the market sets the standards for social care provision and hence for its workforce. Social services can only be provided on the market when the workforce is low paid and lacks extensive employment protection. Migrant workers are attracted to these kinds of jobs and hence often work formally in either agency based or private employment. This could be called a *migrant in the marke*t type of employment.
- In a *Familialistic* care regime (closely approximated by Italian elderly care), market provision is not an option due to limited wage dispersion, while the state is barely involved in the provision or financing of social care. If there is nevertheless a demand for care services, migrants are employed privately and often informally. This has been called a *migrant in the family* type of employment.

Migrant workers were generally found to be less important in childcare than in elderly care, with the exception of the Netherlands. That migrant workers are less common in childcare can be explained by a more limited growth of care needs in this sector, in combination with generally better working conditions and less (night-)shift work. A comparison of the types of employment of migrant workers in childcare and elderly care underlines the importance of cultures of care. Because each of the three countries were for a long time characterised by a Familialistic care regime, there is still a preference for a private, 'mother substitute' type of care. As a consequence, in both the Netherlands and the UK, the private employment of migrant workers is more common in childcare than in elderly care.

There is no evidence that suggests that labour migration policies directly shape the demand for migrant workers. Many migrants employed in the social care sector rely on a residence permit unrelated to employment, or (especially in Italy) are irregularly present. Labour migration policies do, however, shape the circumstances under which migrant workers are employed. Restrictive immigration policies discourage formal agency-based employment and encourage irregular private employment. Meanwhile, the restrictions attached to a work permit or to being irregularly present make migrant workers that fall into these categories more attractive for some employers, because they are willing subordinates that are likely to accept bad working conditions.

Finally, the developments after the 2008 financial crisis suggest that the demand for migrant labour in the social care sector is dependent on economic circumstances. Even in Italy, where private care for older dependents is an occupation largely filled by migrant workers, the crisis seems to have decreased the demand for migrant workers and increased the employment of Italian workers in this sector.

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7 POLICY DEVELOPMENTS: ARE MIGRANT CARE WORKERS A DESIRED SOLUTION?

The previous chapter discussed why migrant workers are employed in social care. It was found that social policies affect the demand for migrant workers in the social care sector, while immigration policies affect the opportunities migrants have to work regularly in formal employment. This chapter focuses on recent developments in social and labour migration policies. It concentrates on the second research question: Why do some states encourage or allow the employment of migrant care workers while others discourage it or opt for alternative means to organise care services? And why is migrant care work sometimes encouraged even in a context of widespread anti-immigrant sentiments?

The chapter starts with a comparative overview of the direct policy responses to migrant care work and the policy developments that are indirectly related to the phenomenon. This is mostly a summary of the findings from the three country case studies presented in chapters 3, 4 and 5. For more empirical details the reader should refer to these chapters. In this chapter the developments in childcare policies are not discussed, because policy developments in this field were hardly related to the employment of or demand for migrant care workers. Instead this chapter focuses only on the developments in elderly care and labour migration policy. In these two policy fields, developments can often be more directly related to migrant care work. After the overview of policy developments, the chapter proceeds by exploring possible explanations for the great variation.

7.1 Policy developments related to migrant care work

Elderly care policies

In Italy, consecutive governments have enacted policies that sustain the employment of migrant workers as elderly carers. The position taken by Italian governments is nicely summarised in the opening quote of chapter 3: it is believed that badanti (migrant care assistants) provide a flexible service adapted to the needs of families (Ministero del Lavoro 2009: 33). This does not imply that many social policies have directly addressed these migrant care workers. In fact, very little has happened at the national level. Only some regional initiatives (mostly in the North) have directly addressed the phenomenon by paying cash benefits to families who regularly hire their

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migrant worker, and by introducing training courses and job mediation services for private care assistants.

At the national level, policy developments indirectly related to migrant care work also indirectly sustain migrant care work, mostly because of the lack of reform. Little has been done to expand public services for the elderly. In the late 1990s some reforms were proposed, but these had little success (Gori 2006: 29). After repeated requests from interest organisations, most notably the three largest pensioners' trade unions, Prodi's second government introduced a national fund for long-term care. However, the introduction of this fund did not change the organisation of long-term care, meaning that local communities continued to have complete discretion over how the funds were spent. While some regions used the extra funds to provide services, others decided to support the employment of migrant care workers, as was described above. Others again did nothing at all.

Throughout the past decade, the attendance allowance (Indennità di Accompagnamento, IA), which accounts for undoubtedly the largest share of public expenditure on elderly care, was not altered. It has been suggested several times that the integration of the IA with other care services would create a more complete elderly care system. However, such attempts have always been unsuccessful (Da Roit et al. 2007: 661). The IA is seen as the backbone of the Italian elderly care system and as such it should not be touched (Interview Ministry of Labour – 2).

In England[94] the employment of migrant workers in the social care sector was received more ambivalently. A Department of Health publication of 2007 stated: 'the independent sector has become increasingly dependent on a migrant workforce, which does nothing to improve the stability of the sector' (Department of Health 2007: 31). However, in 2008, the Department of Health recommended the Migration Advisory Committee that Romanians and Bulgarians should be allowed to work in the sector. The explicit response to migrant care work is hence ambivalent, but, and as will be further discussed in the next section on immigration policies, direct policy responses to migrant care work have been mostly discouraging.

Meanwhile, developments in indirectly related policies are equally ambivalent. On the one hand, the previous chapter has shown that the marketisation of the social care sector has contributed to the greater demand for migrant labour. This marketisation was encouraged by the 1990 NHS and Community Care Act, and only continued further when Labour was in government after 1997. This could hence be seen as an indirectly related policy development that has encouraged migrant labour. Moreover, although attention has moved to labour force

[94] This section refers to England instead of the UK because social care policies are set at the regional level.

issues, the most fundamental problem for the social care sector – namely the limited amount of money available – has not been resolved. Recently the main policy objective has been the personalisation of care through, for example, the introduction of Direct Payments. Trade unions have been concerned that this would have negative implications for the social care workforce. However, spending through Direct Payments is controlled.

In the Netherlands, direct policy responses to the employment of migrant care workers have been negative. There have been some experiments in the late 1990s, but these were all considered to be a failure. Attracting migrant workers has not been considered as a solution for staff shortages in the social care sector since then. Instead, when shortages rose considerably in the late 1990s, large sums of money were invested into attracting sufficient employees. Labour market issues have continued to be an important governmental concern, and investments in the recruitment, training and retention of staff continue. Spending through the Personal Budget that was introduced in the 1990s is controlled. It seems therefore that both direct policy responses and indirectly related policy developments have focused on attracting and training a native labour force.

There is, however, one recent development that puts this finding into question. When the costs of social care increased substantially in the 2000s, several retrenchments were enacted to prevent uncontrollable growth (Regering 2003: 8-9). Most of these retrenchments did not have direct consequences for the workforce. However, the introduction of the Social Support Act (WMO) in 2007 did have large implications for lower-skilled parts of the social care workforce. With the introduction of the WMO, home help services were taken out of the long-term care insurance and instead became a form of social assistance that have to be organised at the local level. As a consequence, marketisation and competition in the home care sector became stronger. Employees have been made redundant and encouraged to work as alpha helpers[95] (see case study chapter 5), while care dependents have lost entitlements to care. The implications of this reform for a demand for migrant labour are not clear yet and it should be remarked that the Dutch government has already taken measures to prevent further redundancies in home care staff. The government also established special 'Mobility centres' to help redundant home care staff to find new employment.

[95] As was described in chapter 5, an alpha helper is a care assistant directly employed by a private person to provide basic home help services. The alpha helper lacks most social security entitlements.

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Table 7.1: Elderly care policies related to migrant care work in Italy, England and the Netherlands

	Direct policy responses	Indirectly related policy developments
Encouraging	Italy: - Regional initiatives including cash benefits	Italy: - Limited public provision (no change) - Unregulated cash for care benefit (IA) England: - Marketisation of social care NL: - Introduction of Social Support Act (WMO)
Discouraging		England: - Introduction of free home care services NL: - Investments in recruitment and training of staff England & NL: - Spending through cash benefits (PB & DP) is controlled

When comparing policy developments in elderly care, the three countries under consideration have followed rather different paths. Italian direct and indirect policy responses have mostly sustained the private employment of migrant care assistants. In the Netherlands, direct and indirect policy responses have mostly discouraged the demand for migrant labour and have explicitly focused on maintaining a suitable native labour force. However, recent developments do not really correspond with this general line. Finally, in England, direct and indirect policy responses have been ambivalent. Although there has been an explicit aim to improve the availability and training of a native labour force, the marketisation of the social care sector has not been reversed.

Immigration policy

In Italy immigration policies have been very positive towards migrant care workers. In 2002, the otherwise highly restrictive Bossi-Fini Act included a regularisation of migrant domestic and care workers already living in the country. The result was a regularisation of 316,000 domestic and care workers. In addition, Italian immigration law allows for yearly immigration quotas to be set by the government. As was shown in table 3.14, the quotas set for the specific group of domestic and care workers were consistently higher than for any other occupation. Moreover, when Romania and Bulgaria entered the EU, their citizens were allowed to be employed as domestic and care workers without any limitations, while restrictions remained in place for most other occupations.

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Recently, the employment of migrant workers in social care has been discouraged in British immigration policy. Until 2007, many care workers arrived in Britain on a specific work permit available for 'senior care workers', referring to home carers and care assistants with a certain level of experience and qualifications. In 2007, a change of eligibility criteria for this work permit was introduced by the Home Office. The new eligibility requirements demanded higher qualifications from the immigrants and a minimum salary. As a consequence, as was shown in table 4.14, the number of granted work permits suddenly plummeted. With the introduction of the new points based system, the wage requirement for senior care workers was raised even further. In the meantime it was decided not to grant nationals from Romania and Bulgaria who entered the EU in 2007 (the A2) special access to caring occupations.

Finally, in the Netherlands, no immigration policies specifically apply to migrant care workers. There was a special arrangement for migrant nurses in the early 2000s, but this was actually more restrictive than the immigration policy applying to other groups of workers. In 2007 only 284 work permits were issued for the entire health and veterinary services sector, compared to a total of some 50,000 (Interview Ministry of Justice). These low numbers might have been the direct consequence of a limited demand for migrant labour in the sector. But even if there was a demand, a work permit would probably not have been issued because social care is considered to be a low-skilled sector. For low-skilled jobs the general policy line is that a sufficient native labour supply should be available. In line with this general policy, no work permits are available for migrant domestic workers.

Table 7.2: Immigration policies related to migrant care work in Italy, the United Kingdom and the Netherlands

	Direct policy responses	**Indirectly related policies**
Encouraging	Italy: - Regularisations (2002 & 2009) - Quotas (since 2002) - A2 nationals unrestricted access UK: - Domestic worker visas	All countries: - Freedom of movement for A8 nationals
Discouraging	UK: - Tightening of eligibility criteria for senior care workers (since 2007) - No access for A2 care workers	NL: - No immigration options for domestic and care workers

In conclusion, both in immigration policy and in elderly care policy, developments have differed markedly across countries. The rest of this chapter will attempt to explain these differences in policy developments.

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7.2 Explaining developments in elderly care policy

In the field of elderly care there have hardly been direct policy responses to the employment of migrant care workers. Meanwhile policy developments indirectly related to migrant care work varied greatly across the three country case studies. In Italy elderly care policies have indirectly sustained migrant care work, while Dutch policies mostly indirectly discouraged it, and English policy developments have been ambivalent. In each of the country case study chapters these policy developments have already been analysed in detail. This section considers which factors have contributed to the policy developments in each country. The expectations formulated in chapter 2 are used to structure the comparison. Understanding the factors contributing to policy developments will eventually help to understand why countries make such different choices regarding the phenomenon of migrant care work.

Expectation B1 asserted that problem pressure – such as increasing care needs – could lead to more investments in social care services. In Italy, public investments are limited and public services are scarce. Meanwhile, the number of people aged 80 and over – those most likely to need long-term care – has grown strongly (see table 1.1) and it is now higher than in all other EU-15 countries. Meanwhile, families are heavily burdened by the care needs of older people. However, the state has not stepped in to reform the Italian elderly care system. In England and the Netherlands, where ageing has been less rapid, there are nevertheless more investments in elderly care. Hence, on an aggregate level expectation B1 does not really contribute to an explanation for the cross-national differences. Yet it could be that problem pressure played a more nuanced role in specific policy choices. To this I will come back below.

Expectation B2 suggested that Social Democratic parties are likely to favour investments in social care services, while Christian Democratic and other conservative parties would oppose them. Looking at the three cases studied, this idea is generally confirmed. In Italy, centre-left coalitions wanted to invest in elderly care, but centre-right government blocked all initiatives to expand and reform public investments (Gori 2006: 31-2). Instead, the centre-right has implicitly and explicitly supported the 'migrant in the family' model of care. In England the Labour party favoured a more comprehensive long-term care system, while Conservatives preferred a private long-term care insurance. In the Netherlands the Labour party consistently favoured more state involvement and higher public investments, while the Christian Democrats emphasised the importance of the subsidiarity of public provisions vis-à-vis the family, and the Liberals the importance of competition among providers.

However, in a cross national perspective, cross-party disagreements fade somewhat. All major Dutch political parties agree that long-term care for the elderly 'is something we should

take care of' (Interview Sting). None of the Dutch political parties favoured a genuine retrenchment of long-term care. To a lesser extent such a consensus can be found in British politics, where all parties agree that 'Something Must Be Done'[96], although they do not agree on how it should be done. Although clear ideological differences exist in Italy, in the end all parties appear to be relatively satisfied with the existing situation of migrant care work. In practice, the party composition of governments has only had a minor impact on policy outcomes. In the Netherlands the Labour party participated in recent retrenchment measures just as much as the Christian Democrats and the Liberals. In England and Italy, Labour and the centre-left were not able to implement their for expansion of elderly care services. Why the party composition of governments has had such a limited impact will be further explored below.

Expectation B3 proposed that interest organisations play a limited role in the development of social care policies. While the beneficiaries of care services are politically weak, limited contributions were expected from trade unions and employers' organisations. In the three case studies the influence of interest organisations differed substantially. In the Netherlands strong stakeholders, especially providers' and clients' organisations, were constantly involved in the policy making process. Their voice was heard and their strong opposition to retrenchment encouraged the government to seek gradual adaptations rather than massive retrenchment. The strong interest organisations also played a direct role in shaping employment conditions. Providers' organisations and trade unions negotiated a collective agreement that guarantees decent employment conditions. When it became clear that the new Social Support Act (WMO), introduced in 2007, resulted in the loss of jobs for care workers, the stakeholders immediately put this issue on the public agenda. They managed to convince the government that measures were needed to prevent a deterioration of employment conditions and to help the redundant care workers to find new jobs.

In England, there are active interest groups in the social care sector, including unions, various providers' organisations and clients' organisations. However, compared to the Netherlands, they do not have such strongly institutionalised access to the policy making process. The Labour government frequently consulted interest organisations on policy making issues, but in the end decisions were made more unilaterally by the government. In Italy, interest groups only had a marginal role. The interest groups involved have been dependent on the willingness of the sitting government to take their opinion into consideration. For example, when pensioners' trade unions submitted a proposal for policy reform, this was just swept away by the then centre-right coalition.

[96] *Timesonline*, 'Hope has faith in future of long-term care', July 3, 2009.

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It is no surprise that interest organisations played such a large role in the Netherlands and a smaller role in England and Italy. As discussed in chapter 2, Pierson has shown that existing social programmes create beneficiaries who can form interest groups, which become a powerful lobby for the preservation of the programme. This brings to the next expectation:

B4 The historical development of social care services affects contemporary policy choices. Policy makers find it difficult to change or retrench existing social care programmes, and to introduce new programmes or investments. This part dependency is stronger when many political veto points exist.

One of the reasons why large investments, once they exist, are hard to retrench is related to the above described role of interest organisations. In addition, existing systems also channel the impact of an increasing need for care services (the increasing problem pressure discussed in expectation B1). In the 1990s in the Netherlands, emerging waiting lists directly put the challenges of population ageing and increasing care needs on the public agenda. Because social care services were provided through a social insurance system which entitled Dutch citizens to receive care services – as was confirmed by a series of court rulings – the Dutch government had no choice but to invest in the sector. Moreover, the obligation to provide sufficient care services also made the staff shortages of care providing organisations a direct problem for the government. Therefore, the government also invested in the recruiting and retaining of a suitable workforce on a large scale.

In the 2000s, these large investments made in the 1990s started to press heavily on the public budget. As a consequence, the government and the largest political parties believed that retrenchments were unavoidable. However, simply retrenching social care entitlements was not an option because strong interest organisations of clients and providers intervened. In addition, it was not what most parties desired. Instead, the government engaged in negotiated and minor reforms, while workforce issues continued to be a high priority. This trend is confirmed by the intention of the new government – that took office in October 2010 – not to retrench investments in elderly care provision.

In Italy, the existing social care system is both residual and highly decentralised. In recent years, this system has not put the national government under significant pressure to enact reforms. This is partly due to the private solution that many families had found for their care needs, as will be discussed below. But even when there were reform intentions under various centre-left governments, the high decentralisation of both funding and decision making regarding social care services posed a big challenge. The central government can increase funding, but it cannot decide how this funding should be used, unless a constitutional change is enacted. Moreover, a reform of the elderly care system would involve a reform of the attendance allowance (IA), but this is politically very difficult. With the large number of Italians

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receiving this cash allowance, its abolishment is highly unpopular. To this should be added the fact that governments in Italy have been highly unstable, making any reform particular difficult. In sum, policy legacies combined with institutional and political fragmentation have contributed to inertia in the Italian social care system.

In England, the impact of existing social care policies is less outspoken. The existing social care system came under pressure more directly than in Italy due to increasing care needs. The problems were most strongly felt on the demand side. A 2006 review of social care (Wanless 2006) found that costs would continue to increase while the system would not fulfil citizens' needs. In the meantime, workforce issues were on the agenda. However, these were not as urgent as in the Netherlands.

Looking at the feedback mechanisms from existing social care programmes, Italy and the Netherlands clearly form two extremes, both in line with expectation B4. The highly developed social care system in the Netherlands pushed the government into even further expansion and investments in workforce issues in the 1990s, while it constrained retrenchment in the 2000s. In Italy, the small, decentralised social care sector with its widespread attendance allowance proved very difficult to expand. The English case is in between. On the one hand, the existing programme has encouraged the government to at least consider expansion and it has put the workforce issue on the agenda. But the pressure was not as large as in the Netherlands, because social care is largely a marketised private sector which in principal has to resolve its own staffing problems.

Let us now, finally, turn to the effects of an already present migrant care workforce, because as will become clear, this has also impacted on policy developments. In the Netherlands, the perceived failure of experiments with migrant nurses in the late 1990s continued to affect policy makers' views in the 2000s. In chapter 5 it was discussed that among the reasons for this perceived failure were cultural differences and language problems. As a consequence, attracting migrant workers to fill the gaps in social care was not seen as an efficient solution. This actually reinforced the need for investments in the native labour force. Interestingly, this implies that, together with skill mismatches and other problems, the fact that the Dutch language is not a widespread language contributed to the difficulty of employing migrant workers. Indirectly these language problems contributed to more investments in the native labour force.

In England, again, developments have been more ambiguous. Views on the desirability of immigration into the social care sector from the Department of Health have differed. On the one hand, there is concern about the deterioration of employment conditions. On the other hand, there is a fear that services will become more expensive if migrant workers are not allowed to

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come in. A representative of the National Care Association, cited in chapter 4, believed that the importance of the phenomenon of migrant care workers has brought the significant workforce problems facing the social care sector to the attention of the government. Yet, whether this has really made a difference remains questionable.

In Italy, the presence of private migrant care assistance relieved the pressure on the elderly care system. The Italian population is ageing at a very high rate and care needs have increased. According to expectation B1, these developments should have encouraged investments in social care, but in practice they have not. In fact, ageing and care needs never became a major public problem. The explanation for this is related to the presence of migrant care workers who already provided a convenient solution for many Italian families. This averted urgent problem pressure, thereby allowing the Italian state to continue along the same road.

In conclusion, the discussion above hints at the importance of path dependent processes in shaping both the (few) direct policy responses to migrant care work and the indirectly related policy developments. Interestingly, these path dependent processes are reinforced by the presence of or experience with migrant care workers.

7.3 Explaining developments in immigration policies

Responses to the employment of migrant care workers have also differed considerably across countries. While Italy has enacted very expansive policies making immigration into the care sector relatively easy, recent policy choices in the United Kingdom have done exactly the opposite. It has become substantially more difficult for migrant care workers to enter the UK. In the Netherlands there are no policies explicitly targeting migrant care workers. This section will also pay some attention to the political processes behind the British decision to allow domestic workers to change employers, and to the complete lack of political attention that has been given to migrant domestic workers in the Netherlands. The expectations formulated in chapter 2 are again used to structure the comparison.

In chapter 2 it was suggested that left-wing political parties may be more inclined to enact expansive immigration policies (C2), while the electoral strength of populist or radical right parties leads to more restrictive policies (C3). In Italy, the centre-left was indeed generally more positive towards immigration than the centre-right. It introduced larger quotas (in 2006) and it opened the labour market for A8 nationals. The centre-right was generally more critical of immigration. A strongly anti-immigrant rhetoric was part of the electoral campaigns of right-wing parties and the centre-right enacted more restrictive policies, such as the 2009 Security Package. However, when looking at the specific field of migrant care work, then both left-wing

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and right-wing governments, the latter even including the strongly anti-immigrant Lega Nord, enacted expansive immigration policies. In 2008, the only group for which the centre-right government still made quotas available was that of domestic and care workers. In 2009 a special regularisation was even enacted for that specific group. There are seemingly no large cross-party differences when it comes to this specific group of workers.

In the UK, the Labour government generally took a positive stance towards labour immigration. In 2004 it even decided to open the British labour market to all citizens from the countries that had just entered the EU (the A8). Yet after the enormous inflow of A8 citizens, immigration policies generally became more restrictive, and it was still the Labour government that was responsible for tightening eligibility criteria for the entrance of social care workers in 2007.

In the Netherlands the increasing strength of different parties with a radical right position influenced the whole immigration debate. Both centre-left and, more explicitly, centre-right governments and parties have taken a reticent position on the issue of migration. This made it very difficult, for example, for organisations of migrant domestic workers to even get their demand for work permits on the political agenda. In general, although centre-left parties were a little more positive towards immigration, there is no clear impact of government composition and party preferences on the differential migration policy outcomes.

Another expectation raised in chapter 2 concerned the influence of interest organisations:

> *C1 Strong employers' organisations encourage the government to enact expansive immigration policies. The role of trade unions is more ambivalent and might depend on whether migrant workers replace or supplement native workers.*

Among the three cases, employers' organisations were clearly the strongest in the Netherlands, and yet these have rarely lobbied the government for more expansive immigration policies for care workers. In the UK, on the other hand, employers' organisations actively lobbied against the restrictions on work permits for senior care workers. The organisations were heard by the government, but the only thing they achieved were minor relaxations of the eligibility criteria.

In Italy, there were no significant employers' organisations lobbying for the interests of employers (families). Therefore, the fact that immigration policies for migrant care workers were so expansive in this country can in no way be related to any organised lobbying by employers' organisations. The strength of employers' organisations apparently has no impact on the enacted policies for migrant care workers.

Expectation C1 suggests that the position of trade unions depends on whether migrant workers replace or supplement native workers. This is in practice often difficult to tell. What can be said, however, is that migrant care workers in Italy are employed in a type of work that

previously barely existed. The migrant workers have therefore certainly not replaced Italian care assistants, but instead they have come to fulfil a new demand. In the UK and the Netherlands, migrant workers in agency-based employment are working in a sector that forms an important base for the employment of native workers too. However, there is no evidence of native employees in the social care sector feeling that they are threatened by migrant workers in any of the countries.

In the UK, trade unions joined the employers in their lobby for expansive immigration policies, because: 'we believe that migrants play a key role in the provision of public services in this country' (Interview UNISON – 1). As was noted above, this lobby was not very successful. In Italy trade unions as well as Catholic associations lobbied for more expansive policies for migrant care workers. Whether this lobby had an important impact has to be questioned too. The organisations themselves acknowledge that while the centre-left tended to listen to their demands, the centre-right excluded them from any involvement in migration policy making. Only in the Netherlands do the trade unions take a more negative stance on immigration policy. Contrary to their British and Italian peers, they opposed opening the labour market for A8 nationals. They also refused to lobby the Dutch Parliament for a work permit for domestic workers. Although the differences in positions taken by trade unions are very interesting – and worthy of further study – it does not really help us to understand differential policy choices.

Another expectation raised in chapter 2 concerned the influence of policy venues:

C4 When decisions on immigration policies are made in technocratic, bureaucratic or judicial venues and there is no open debate in the electoral arena, it is more likely that these immigration plicies are expansive.

What we find in the three case studies is quite the opposite of what this expectation predicts. Only in Italy – the country where migration policies for migrant care workers were expansive – were policies for migrant care workers really a political issue, discussed openly in the media and decided upon directly by the government. In both the Netherlands and the United Kingdom these policies were more of a bureaucratic affair. In the UK an expert committee (the MAC) advised a government department, while in the Netherlands there is a governmental agency that has the discretion to decide which labour migrants to allow in.

The last expectation to be evaluated concerns the impact of differential historical experiences with previous immigrations on contemporary policy choices (C5). Italy has a very different immigration history than the Netherlands and the UK. While colonial and guest worker migration already accounted for large inflows of immigrants into the UK and the Netherlands in the 1960s, Italy only became a country of immigration in the 1980s. Both the UK and the Netherlands experienced that guest workers may stay in a country even if their labour is no longer specifically requested. This experience may have contributed to the countries' concurrent

hesitancy to enact temporary labour migration programmes and immigrant regularisations, although labour migration into the UK is still considerable (see Appendix table A-3). Italy, on the contrary, has issued several large regularisations and has issued large quotas of work permits, apparently not concerned by the possible unintended long-term consequences of immigration.

Historical differences may be a plausible explanation for Italy's different stance on immigration in general, but it cannot explain why domestic and care workers have assumed such a special position in immigration policies in recent years. All the explanatory factors discussed above cannot really account for contradictory policy developments in Italy, the UK and the Netherlands. How can these developments then be explained? I suggest that immigration policies were affected by existing long-term care systems. In the Familialistic Italian welfare regime, care is a family affair. As a result, care work is hardly considered to be a normal job: 'in fact to date, even from a legal point of view, it is not considered a real job' (Interview Acli Colf).

As a consequence, the evolving debate is about families' needs, instead of about labour market issues. It is assumed by many interest groups and political parties that migrant care assistants 'provide a service that today is vital for Italy, for the families' (Interview Acli Colf). These needs of families form a legitimisation for expansive care policies. When pleading for a regularisation of migrant care assistants in 2009, Minister Carlo Giovanardi (belonging to Berlusconi's party PdL) argued that 'we have to take into account the worries of families'[97]. The newspaper *Il Giornale,* which is otherwise highly critical about immigration, wrote about 'the domestic workers that contribute to the wellbeing of families'[98]. The positive view of migrant workers helping out families is widely shared, as is shown in various citations in chapter 3. Apparently, the family needs' argument overrules anti-immigrant sentiment.

On the contrary, where long-term care has become a largely formal sector, as is the case in the United Kingdom and the Netherlands, social care is a job in which large numbers of people are 'normally' employed. As a consequence, the same rules apply to immigrants working in the social care sector as to immigrants working in other sectors of the economy. Family needs are not considered to be a relevant argument: 'The Home Office has just never really bought it, they just weren't interested'[99] (Interview Kalayaan). Instead, the main concern in both the United Kingdom and the Netherlands was whether migrant care workers should be considered skilled workers. In the Netherlands this was not considered to be the case: 'when it involves care, especially home care, then it's all low-skilled work' (Interview Ministry of Justice). In the

[97] *La Repubblica,*' Regolarizzare colf e badanti ma nel governo è Scontro', 06-07-2009.
[98] *Il Giornale*, Badanti, una selezione per diventare "regolari"', 10-07-2009.
[99] This quote refers to a lobby for work permits for domestic workers in the United Kingdom.

UK, eligibility criteria were tightened because it was feared that migrants came in to work in jobs that were 'not genuinely skilled' (Interview Home Office).

Illustrative of the very different ways in which policy makers see migrant care work is the reaction to the economic crisis in the United Kingdom and Italy. In the UK, the Migrant Advisory Committee advised against opening the labour market to social care workers, regardless of evidence showing labour shortages. In particular, the Migration Advisory Committee was concerned about the impact of the economic crisis:

> *In social care, there was some evidence of labour shortage. But we are concerned about the uncertainty of the volume [...] and the labour market impact of such flows at a time of economic downturn. [Therefore] we do not recommend a scheme for social care (MAC 2008a: 9).*

In Italy, on the contrary, the economic crisis was a reason to terminate quotas for all jobs, except for domestic workers and care assistants (see table 1):

> *This is the need of families, but the other economic sectors at this moment have no need for foreign workers. We have many Italian and foreign workers that are losing jobs (Interview Ministry of Labour – 3).*

These examples underline the importance of existing care systems for labour migration policies. Where social care is a largely formal sector, immigration policies make no exceptions for the specific group of migrant care workers. Where social care is largely a family affair, on the other hand, special policies are enacted for the migrant workers that are needed by families.

7.4 Conclusion

This chapter has investigated the policy developments related to migrant care work in the elderly care sector. Looking at elderly care policies, there are very few policies that can be seen as a direct response to the employment of migrant care workers. There are, however, many policy developments that are indirectly related to the demand for migrant workers in the sector. These policy developments differed strongly by country. These differences can best be explained by feedback mechanisms from the existing social care system and, interestingly, by the importance of migrant workers already employed.

The highly developed social care system in the Netherlands pushed the government into an even further expansion and investments in workforce-related issues in the 1990s, while it constrained retrenchment in the 2000s. Strong stakeholders, including clients organisations, providers' organisations, and trade unions, together formed a powerful lobby for the preservation of existing care entitlements and employment conditions. In addition, the fact that experiments with the employment of migrant workers had failed encouraged the government to increase investments in training and retention of native employees.

In Italy, the small, decentralised social care sector with its widespread attendance allowance proved very difficult to expand or reform. This was due to political and institutional fragmentation, but also to the availability of migrant care workers. The presence of a cheap migrant labour force presented the families with a convenient solution. In the meantime, the state had never come under real pressure to expand its provision of elderly care services.

The English case is more ambivalent. The social care sector is to a large extent publicly funded. Therefore, the increasing demand for services and the staff shortages faced by private providers are issues for public concern. This has encouraged the government to enact some minor expansions of the provision of services and to introduce some investments in the training of new staff. Policy makers' views on the desirability of migrant workers have differed, but in general the presence of these migrant workers has helped the private sector to continue providing services at low costs. The ambivalent policy developments fit with the mixture of public and private responsibility in the English social care sector. The pressure on the government to guarantee provision and decent employment conditions is not as large as in the Netherlands, probably because social care is largely provided by the private sector which, in the end, has to resolve its own staffing problems. Meanwhile, a large social care reform has been on the agenda for a long time, but the direction in which this will go is still unclear.

Labour migration policies enacted for the specific group of migrant care workers were also found to be affected by existing care systems. In Italy where care is still very much a family affair, choices in immigration policy are related to family needs. Due to the needs of families, expansive immigration policies were acceptable, in spite of strong anti-immigrant sentiment. In the United Kingdom and the Netherlands, social care is more defamilialised. It is essentially considered as a 'normal' employment sector. In these countries, central in the discussion about migrant care work were not the needs of the beneficiaries of the care services, but the needs of the labour market. This did not legitimate any exceptional policies for the specific group of migrant care workers.

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8 CONCLUSION: MIGRANT CARE WORK IN EUROPEAN WELFARE REGIMES

The two previous comparative chapters have already extensively discussed the results of this research project. What is left for the conclusion is bringing together the findings regarding the practice of migrant care work, and the policy responses to it. In addition, this concluding chapter will flesh out the main theoretical contributions of this study, and it will raise some moral issues that deserve consideration. The chapter finishes with a short outlook on the future of migrant care work in European welfare states in the context of the 2008 financial crisis and continuing population ageing.

This study has analysed the role of migrant workers in social care and the policy developments related to this phenomenon. Migrant workers have been attracted to work in social care because of population ageing, changing gender roles and the resulting increase in demand for care services. The phenomenon is related to the future of social care in both the countries that receive migrant workers, and the countries that these workers have left behind. Moreover, research on migrant care work sheds new light on the interaction between immigration and welfare regimes in Europe.

In this research project, different types of migrant care work were distinguished according to whether the employer is an organisation ('agency-based employment'), or a household ('private employment') and whether the employment relationship is formal – in line with all regulation – or informal. Policy developments were categorised distinguishing direct policy responses and indirectly related policy developments, as well as policies encouraging and discouraging migrant care work.

Since research on migrant care work is still scarce – though growing – this study has been largely exploratory. It has relied on a variety of data sources, ranging from survey data to newspaper articles and expert interviews. Not all these sources are equally reliable. This is also a shortcoming of this research. The data used to identify the importance of migrant workers were sometimes only sketchy, based on expert interviews or newspaper articles. Moreover, different data sources were used for each of the countries studied, making it difficult to compare the results. Nevertheless, the consistency of the findings across different data sources suggests that the findings are sufficiently reliable. It is for future research to address these data limitations.

The three selected cases conveniently represented highly contrasting patterns in elderly care. However, with hindsight the case selection was not ideal for studying developments in the

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area of childcare, where each of the countries had an almost similar background of a male breadwinner model and a Familialistic care regime. A comparison with a country that more resembles the Social Democratic ideal type, such as Sweden, or a country where a market sector developed earlier, such as the US, would have been valuable. In the results presented below findings from the elderly care sector are central.

8.1 Main findings

Chapter 6 showed that the employment of migrant workers in social care is related to working conditions. Migrant workers work longer hours and more (night) shifts than their native peers, they are overrepresented in sectors that are low paid, that require a lot of shift work, and that lack career opportunities. Such circumstances can be found in formal, agency-based employment in Liberal labour market regimes, but also in formal or informal private employment in more Coordinated labour market regimes.

At an aggregate level public investments in social care seem to crowd out the demand for both private and agency-based employment of migrant workers. Yet a closer look at how social policies shape migrant care work shows that it is useful to take into consideration care regimes as a package including social care policies, employment patterns, and cultures of care. This shows that an ideal-typical Familialistic care regime – as was approached by elderly care in Italy – fosters the emergence of a *migrant in the family* model of care, while an ideal-typical Liberal care regime – which was found partly in English elderly care – induces a *migrant in the market* model of employment. A Social Democratic care regime – of which Dutch elderly care shows many characteristics – does not create a particular demand for migrant workers.

In the area of childcare it was more difficult to draw conclusions because of a limited variation between the cases. Childcare in each case showed many characteristics of a Familialistic care regime, supplemented by some Social Democratic (Italy and the Netherlands) and Liberal (the UK and the Netherlands) elements. The Familialistic legacy in all countries may explain why parents more often opt to employ migrant workers privately, as nannies or childminders. The fact that well-off English parents, contrary to Dutch and Italian parents, can not rely on any public provision or public support probably explains why they most often employ a foreign nanny.

Labour migration policies do not directly affect the demand for migrant workers. Many of the migrant workers employed in social care had entered the country on non-work-related visas (as refugees or for family reasons) or they were employed irregularly. Nevertheless, labour migration policies are important for the circumstances under which migrant workers are

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employed. They determine whether migrants who are dependent on work permits can work in formal agency-based and private employment. When work permits are unavailable, this encourages informal private employment.

Chapter 7 has shown that most policy choices in elderly care do not directly target migrant workers, yet indirectly – and often unintentionally – they significantly affect the demand for migrant labour. Though many specific national factors influence policy developments, from a comparative perspective these developments are most strongly influenced by path dependent mechanisms. Existing social care systems clearly affect contemporary policy choices. Moreover, and here we finally arrive at the interaction between policy and practice, policy developments are also influenced by the presence of migrant workers.

In Italy the large scale employment of migrant workers decreased the need for public services. The availability of private migrant care workers absolved the Italian state from reforming its social care system. In the UK, the willingness of migrant workers to work long hours and night shifts for low pay enabled private sector care providers to continue to provide services at low costs. Local governments profited, because they could also purchase these services at low costs. In the Netherlands, on the contrary, the fact that migrant workers were not seen as a solution – due among other things to language problems – encouraged public investments in education, training and employment conditions.

Meanwhile, labour migration policies for migrant care workers were also found to be affected by existing care systems. In Italy, where care is considered to be a family affair, special provisions for this group of workers were legitimised by a reference to families' needs. By contrast, in the UK and the Netherlands, care work is considered to be a normal job. In these countries the main debate evolved around skill shortages on the labour market and there were no special policies enacted for migrant care workers.

Combining the findings on the employment of migrant workers in social care and the policy developments related to this phenomenon, what stands out is the strength of a self-reinforcing mechanism. Tentatively, three typical patterns can be distinguished. In a Familialistic care regime, migrants are attracted to work as private care assistants. As a consequence, there is no need to provide more public services. Meanwhile, special labour migration policies are enacted to cater for the needs of families. The result, though hardly intentional, is an institutionalisation of the 'migrant in the family' model of care work.

In a Social Democratic care regime there is no particular demand for migrant workers. Investments in publicly financed services crowd out the demand for private care workers, while investments in decent employment conditions ensure that a sufficient number of native employees is willing to work in the sector. These investments are reinforced by strong

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stakeholders and by general public support. Meanwhile, no special immigration policies are enacted. As a result, the employment of migrant workers continues to be limited.

Finally, the findings for the case that most approached the typical Liberal care regime in this research project are more ambivalent. Migrants are attracted to work in agency-based care, which in this study has been called a 'migrant in the market' model of care work. Yet, no special immigration policies are enacted for this group, because the work is considered to be a normal job. In a typical Liberal care regime, the availability of cheap migrant workers should decrease the need for public investments. In the UK, however, with public investments in the social care sector being already quite large, the employment conditions and the difficulty of recruiting and retaining staff are also a public concern. How this will impact on future needs for migrant care work will be addressed in the last part of this chapter, which focuses on the likely effects of financial and demographic challenges on each of the cases.

8.2 Theoretical implications

The findings of this study have implications for various literature sources that were addressed in chapter 2. First of all, this research project has contributed to the existing research on migrant care work by comparing private and agency-based employment of migrant care workers. A framework has been developed that can be used to understand both types of care. This study has shown that contextual factors, most importantly existing social care systems, strongly influence the demand for and types of employment of migrant care workers.

Second, the assumption that migrant workers are attracted to and overrepresented in "bad" jobs characterised by unpleasant working conditions (Piore 1979; Waldinger and Lichter 2003; Anderson and Ruhs 2008) has been confirmed. Most striking among the unpleasant working conditions that encourage the employment of migrant workers is working (night) shifts and living with an employer.

Third, this study has shown that the role of foreign workers should be taken more seriously in studies of welfare regimes, and care regimes specifically. Migrant workers can be welfare providers and as such affect 'the combined, interdependent way in which welfare is produced and allocated between state, market, and family' (Esping-Andersen 1999: 35). The results of this study suggest that employment patterns of migrant workers are largely complementary to existing care regimes, leading to a 'migrant in the family' and a 'migrant in the market' model of care.

Although the employment of migrant care workers is strongly shaped by existing care regimes, that does not imply continuity. Path dependency is often associated with inertia.

Pierson argues: 'once such a process has been established, positive feedback will generally lead to a single equilibrium. This equilibrium will in turn be resistant to change' (Pierson 1993: 44). Esping-Andersen once spoke of a 'frozen continental landscape' found in countries such as Italy, Germany and France (Esping-Andersen 1996). Yet the developments this research found in Italy are anything but frozen. Though not induced by policy change, the employment of migrant workers has led to a transformation of the Italian care regime.

Fourth, the findings of this research project also have some theoretical implications for the 'politics of the welfare state' because decisions were sometimes found to be influenced by the presence or absence of migrant workers. The presence of migrant care workers in Italy absolved the state from acute pressure on its care system. The fact that migrant workers were not seen as a convenient solution reinforced investments in a native labour force in the Netherlands. If we push this point a little further, this last finding also hints at a rather unexpected relationship between language and welfare state politics. One of the reasons why migrant workers were considered not to be a solution for staff shortages in the Netherlands was their limited knowledge of the Dutch language. In the United Kingdom, on the contrary, language formed much less of a barrier. So, when we want to understand policy developments in the social care sector, the availability of migrant labour, and the extent to which this is considered to be a convenient solution, have to be taken into account.

Finally, regarding the politics of immigration this study has found that labour migration policies can be influenced by existing care regimes. So far, research on the interrelation between welfare states and migration has primarily considered migrants as (potential) welfare dependents or the claimants of social rights (for example Bommes and Geddes 2000a; Guiraudon 2000; Sainsbury 2006). Yet this study has shown that we should also take into consideration the role of migrant workers as welfare providers. We can only understand the very different developments in migration policies for care workers if we take into consideration the extent to which care has been defamilialised. Where social care is a large formal, agency-based sector, immigration policies tend to consider care workers as normal workers and no exceptional policies are enacted. Conversely, where social care is a family affair, families' needs legitimise special policies allowing the employment of migrant workers in the sector.

8.3 Issues for consideration

The global care chain literature (Anderson 2000; Parreñas 2001; Ehrenreich 2002; Lutz 2002) has pointed at a range of important moral issues related to migrant care work. It has shown, for example, that global inequalities urged women from poor regions to leave behind their own

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family in order to work for wealthy households elsewhere. These migrant women often found themselves in very bad working conditions, sometimes being treated almost like a slave. Discussing these moral issues was not the aim of this dissertation, and therefore they received very limited attention so far. In this section though, I want to mention some of the ethical issues that came across in this research project, without exploring them in detail. I will only discuss implications related to the role of migrant workers in receiving countries. Not taken into consideration, therefore, are very important issues related to the personal circumstances of the migrants in question, and to their country or origin, where new care gaps may emerge.

First, as has been discussed in chapter 6, one of the reasons why migrants are found to be attractive workers is their vulnerability. Foreign workers are sometimes working under conditions that no native worker would accept, simply because foreign workers have no alternative. They are tied to their employer through work permits, or they are irregularly living in the country. Ironically, the workers are willing to provide welfare services, because they are not covered by the protections offered by the welfare state. A migrant care assistant who is working irregularly cannot take sick leave, cannot enforce legal working hours, and when she or he is fired, there are no unemployment benefits. These are exactly the reasons why a migrant worker is the willing subordinate that is so attractive for an employer. When migrant workers obtain more rights, through regularisation, or by obtaining a permanent residence permit, they automatically lose some of their attractiveness. This utilisation of the vulnerability of migrant workers hardly fits the ideals of equality or equal opportunity so important in European welfare states.

Second, migrant care work is a strongly gendered phenomenon. Foreign women are attracted to work in jobs which native women do not want to do. Especially in Italy, the presence of these foreign women enabled native women to work in other occupations. Women's unpaid work within the household is replaced by (low) paid work carried out by other women. Meanwhile, there is no redistribution of household chores between women and men. Moreover, the shift from unpaid to paid work is only possible for women who earn a sufficient amount to be able to afford to employ a private care assistant. Employing a migrant care worker is only a solution for the well-off.

The fact that care work is women's work also has implications for pay and employment conditions. The skills involved in social care are often undervalued. Because it is women's work, 'everyone can do it'. The fact that it is also a highly demanding task which involves considerable social and physical skills is not always recognised, and it is often not recognised in pay levels. In addition, as became clear especially in the discussion of Dutch policies for domestic workers, the fact that it is women's work also justifies a lack of social protection.

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Because it is expected that women can rely on their husbands' social insurance and pension, social protection for domestic workers – even when their employment is publicly financed through the Social Support Act – is not necessary.

In conclusion, the demand for migrant workers in the social care sector is related to an undervaluation of care work. Although it does give native women more opportunities to engage in paid work, it does not really change existing gender inequalities. Moreover, the employment of migrant workers to fill the gaps in European care services is only a solution because these migrant workers are excluded from European welfare provisions.

8.4 The financial crisis, population ageing and the future of migrant care work in European welfare regimes

In 2008, the world was hit by financial crisis. Besides collapsing banks and stock markets, a recession and a sharp increase in unemployment rates occurred in all European countries. As was discussed in chapter 6, in the short run the financial crisis led to a smaller demand for migrant workers in each of the case studies, because high unemployment rates resolved acute labour shortages. What the consequences of the financial crisis will be in the long run is another question.

In order to alleviate the immediate impact of the financial crisis, states have spent large amounts of money on interventions ranging from bank bailouts to part-time unemployment benefits. As a consequence, public debts have increased strongly. These debts have to be repaid some time, and as a result social spending might come under pressure. The first signs of welfare state retrenchments are already visible in the Netherlands and the UK. Meanwhile, European populations continue to grow older. The result is a growing need for elderly care services, while a decreasing share of the population is of working age. This will both put the financial situation of the welfare state under further pressure, and lead to even bigger staff shortages in the social care sector.

How will imminent retrenchments combined with population ageing impact upon the demand for migrant care work in different care regimes, especially in elderly care? I suggest that this would not directly affect the Italian 'migrant in the family' model of care. Public spending on social care is already low. Retrenchments and increasing care needs will only reinforce the dependence on privately hired migrant workers. The 'migrant in the family' model of care will be consolidated.

The impact could be much larger for the Netherlands, where the employment conditions and the availability of elderly care services largely depend on public investments.

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Rretrenchment of public investments could induce a demand for both agency-based and private migrant care workers. So far, the stakeholders in the sector have managed to secure investments in workforce recruitment and retention. Interestingly, the new right-wing government – supported by the extreme right party of Geert Wilders – has chosen to shelter the elderly care sector from retrenchments. This choice fits with the findings of this study regarding the path followed by a Social Democratic care regime. Whether public investments will continue to be sufficient to cover the needs of the Dutch elderly and to provide good employment conditions for social care workers, will only become clear in the future.

In a typical Liberal care regime, public funding for social care services is limited. Therefore, growing public deficits should not have a direct impact upon the organisation of social care. Although the elderly care regime in the United Kingdom resembles the Liberal ideal type in some respects, there is also a strong dependency on public funding. What the consequences of financial crisis and population ageing will be, depends on the results of the reform of the social care system that has been planned for so long. If the system remains unchanged, then a demand for migrant workers is likely to grow only further. Whether these immigrants will be employed formally by care providing organisations, or privately directly by families, might depend on the choices made in immigration policy. If these continue to be restrictive, then the only option left could be the employment of irregular migrants as private care assistants, following the Italian example.

This study has demonstrated that migrant care workers have become an element of European welfare regimes. With the current financial problems and continuous population ageing, the dependence on migrant workers in the social care sector is likely to grow almost everywhere. The results of this study have shown that social care policies affect the demand for migrant workers, while immigration policies shape the extent to which they can work regularly and under good conditions. Therefore, in conclusion, policy makers play an important role in deciding what the future of migrant care work in European welfare regimes will be.

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APPENDIX A: ADDITIONAL TABLES

Table A-1: Living arrangements of older people and contact with children

	Percentage of people aged +65 (2008):				Percentage of people aged +80 (2004):	
	living alone		living with others than spouse[1]		living with child or in same building	contact with child at least daily
	Men	Women	Men	Women		
Denmark	29	56	3	3	6	39
Sweden	28	53	4	3	3	33
Netherlands	19	49	6	5	3	29
United Kingdom	26	45	13	15	...	...
France	21	49	14	11	15	51
Germany	22	44	7	6	33	54
Austria	19	45	23	22	38	60
Italy	16	40	32	29	42	79
Spain	10	26	40	42	41	81
EU-15 average	20	42	19	19	...	...

Sources: data for people aged +65, Eurostat (2010: 93); data for people aged +80, Kohli et al. (2005).
[1] With or without spouse 93.

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Table A-2 Recipients of informal unpaid care as percentage of all dependent people aged 50 and over (2004)[1]

	Received some form of informal unpaid care	Receiving intensive personal care from within the household	Type of informal care received as percentage of all receiving informal care from outside of the household:			
			Care on a daily base	Administrative help only	Home Help[2]	Personal care[3]
Denmark	57	9	13	9	79	14
Sweden	59	15	12	16	70	14
Netherlands	50	14	17	20	65	16
United Kingdom	…	…	…	…	…	…
France	57	21	35	11	72	17
Germany	66	21	31	4	66	29
Austria	68	21	28	4	69	27
Italy	58	30	44	11	45	44
Spain	56	32	43	12	56	32

Source: SHARE data edited by SCP (2007d)

[1] Informal unpaid care is all care provided by relatives, friends, neighbours and volunteers for which there is no financial compensation (SCP 2007d: 47). In the table two different definitions of dependency are used. While the first three columns refer to people with moderate or sever physical, psychological or mental limitations who also experience these limitations as problematic, the last four columns (regarding care received from outside of the household) refers to all people with moderate or severe physical, psychological or mental limitations.

[2] With or without administrative help.

[3] With or without administrative and home help.

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Table A-3: Permit-based migration, inflow of asylum seekers, naturalisation rate, foreign (born) labour force and women as a percentage of foreign labour force.

	Permit-based migration by category of entrance, 2008			Average inflow of asylum seekers (1997-2008)	Average naturali-sation (1997-2008)	Foreign born labour force		Foreign labour force		Women as % of foreign labour force	
	Family	Free movement	Work			1999	2008	1999	2008	1999	2008
	per 1000 population				*% foreign population*	*% of total labour force*				*% of foreign labour force*	
Denmark	1.1	2.7	1.1	1.0	3.9	...	6.8	3.4	4.8	43	46
Sweden	3.7	2.8	0.1	2.5	7.5	9.8	11.2[1]	5.1	4.3[1]	50	48[1]
Netherlands	1.3	2.3	0.6	1.5	6.1	8.7	11.4	3.5	3.9	...	43[2]
United Kingdom	1.8	1.6	1.7	0.9	3.8	...	12.6	3.7	7.8	46	43
France	1.4	0.6	0.4	0.7	...	...	11.8	5.8	5.6	37	42
Germany	0.6	1.4	0.3	0.8	1.8	?	?	8.8	9.4	36	41
Austria	1.7	3.8	0.1	2.5	3.6	12.3	16.3	10.0	13.4	37	40
Italy	2.3	3.2	1.6	0.3	0.9	...	10.3	4.0	6.6[2]	30	36[1]
Spain	1.8	4.3	2.6	0.2	1.3[4]	3.8	18.2	1.1	8.2	31	42
EU-15 average[3]	1.7	2.5	1.0	1.2	3.6	8.0	11.8	4.6	7.0	39	41

Source: OECD (2011c).

[1] Data for 2006.

[2] Data for 2007.

[3] Average of data presented in table.

[4] Average of 1997-2002.

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Table A-4: Opinion data related to long-term care and immigration

	In which way would you prefer to be looked after?				Who should provide care? (percentage totally agree/tend to agree)			Institutions such as nursing homes offer insufficient standards of care	Immigrants take away jobs from native-born workers	Immigrants bring down wages
	In own home:			Long-term care institution	Public authority	Children should pay for care	Care provided by relatives[2]	(Percentage agreeing with statement)		
	By relative	Professional care services	Personal care[1]							
Denmark	20	46	21	7	97	12	18	36	...	...
Sweden	34	29	20	12	97	15	7	53	...	...
Netherlands	33	42	12	8	96	22	23	45	25	28
UK	44	28	10	5	95	24	30	47	54	48
France	23	43	15	10	96	48	17	45	17	34
Germany	48	24	12	7	91	31	35	37	31	43
Austria	39	24	12	11	94	38	28	41	...	...
Italy	44	19	16	8	88	68	48	53	25	40
Spain	48	19	9	11	96	69	40	37	37	55
Average EU-15	39	28	13	9	95	40	28	45	31[3]	42[3]

Sources: opinion data on long-term care, Eurobarometer (2007); opinion data on immigrants, Transatlantic Trends (2009).
[1] Hired by you or your family.
[2] Even if at the cost of the career of the relative.
[3] Average of European countries present in study.

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APPENDIX B: LIST OF EXPECTATIONS

Why migrants work in social care

A1 Migrant workers are employed in "bad" jobs characterised by unpleasant working conditions, limited chances of job mobility, a personal relationship with the employer, and possibly by low pay.

A2 Demand for migrant labour increases in times of economic boom, when native workers have the opportunity to move up, and decreases in times of economic downturn.

A3 In a Liberal labour market regime migrant workers are more likely to be overrepresented in formal care work.

A4 Public investments in social care crowd out demand for all types of migrant care work.

A5 Cash allowances, especially when unregulated, lead to a demand for migrant workers employed privately and informally.

A6 Care regimes as a package of care policies, employment patterns and culture shape the type and extent of migrant care work.

A7 Expansive immigration policies for migrant care workers encourage their employment.

A8 Restrictive immigration policies push immigrants into informal private employment.

A9 The vulnerability of immigrants that are irregularly present or dependent on a work permit could make these migrant workers more attractive for employers.

Explaining developments in social care policies

B1 Problem pressure – such as increasing care needs – leads to more investments in social care services.

B2 When they are in power, Social Democratic and other left-wing parties encourage public investments in social care services. Conversely, Christian Democratic and other conservative parties discourage public investments in social care services.

B3 Beneficiaries of care services – care dependents or informal carers – are politically weak and unable to influence policy outcomes.

B4 The historical development of social care policies affects contemporary policy choices. Policy makers find it difficult to change or retrench existing social care programmes, and to introduce new programmes or investments. This path dependency is stronger when many political veto points exist.

Explaining developments in immigration policies

C1 Strong employers' organisations encourage the government to enact expansive immigration policies. The role of trade unions is more ambivalent and might depend on whether migrant workers replace or supplement native workers.

C2 When they are in power, left-wing parties may be more inclined to enact expansive immigration policies, but both the left and the right are internally divided by the issue of immigration.

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C3 The electoral strength of populist or radical right parties leads to more restrictive immigration policies.

C4 When decisions on immigration policies are made in technocratic, bureaucratic or judicial venues and there is no open public debate, it is more likely that these immigration policies are expansive.

C5 Historical experiences with immigration affect contemporary policy choices. In particular, negative historical experiences lead to more restrictive immigration policies.

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APPENDIX C: LIST OF INTERVIEWS

A total of 38 persons were interviewed in a total of 32 separate interview sessions. In addition, many more and less formal conversations were held with experts in each of these countries. These are not listed here. The number of persons present during an interview is shown between brackets (if more than one).

Italy

Civil servants:

1. Ministry of Labour – 1: Ministry of Labour, Health and Social Policy (Ministero del Lavoro, della Salute, e delle Politiche Sociali), Directorate for policies for children and adolescents (Politiche per l'infanzia e l'adolescenza), Rome, 15 April 2009.
2. Ministry of Labour – 2: Ministry of Labour, Health and Social Policy (Ministero del Lavoro, Salute, e Politiche Sociali), Directorate for policies for people with disabilities (Dirigente Politiche per le persone con disabilità), Rome, 15 April 2009.
3. Ministry of Labour – 3: Ministry of Labour, Health and Social Policy (Ministero del Lavoro, della Salute, e delle Politiche Sociali), Directorate for immigration (Direzione Immigrazione), Rome, 15 April 2009.

Interest group representatives:

4. FILCAMS CGIL: Federation of Italian Workers in Commerce, Hotels, Catering and Services belonging to the Italian General Confederation of Workers, Rome, 12 June 2008.
5. INAS CISL: National Institute for Social Assistance belonging to the Italian Confederation of Trade Unions, Rome, 17 July 2008.
6. CGIL: Italian General Confederation of Worker, Directorate for immigration, Rome 24 July 2008.
7. UILTuCS & UIL (2): Italian Labour Union for Tourism, Commerce and Services & Italian Labour Union, Rome, 24 July 2008.
8. Acli Colf: Catholic organisation for domestic workers, Rome, 16 April 2009.
9. SPI CGIL: Pensioners Trade Union belonging to the Italian General Confederation of Workers, Rome, 17 April 2009.
10. Caritas: Caritas Italiana, Rome, 20 April 2009.

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United Kingdom

Civil servants:

11. Department of Health: Department of Health, Social Care Strategy, London, 9 December 2008.
12. Home Office: Home office, UK Border Agency, Croydon, 1 December 2008.
13. Department for Children, Schools and Families (4): London, Wednesday 10 December 2008.
14. Director of Adult and Older People Services: London Borough Greenwich, 18 November 2008

Interest group representatives:

15. UNISON – 1: National Development Manager for Migrant Workers of the public sector trade union UNISON, London, 3 November 2008.
16. UNISON – 2: National Officer Local Government Service Group of the public sector trade union UNISON, telephone interview, 24 November 2008.
17. Kalayaan (2): Organisation for migrant domestic workers, London, 10 December 2008.
18. NCA: National Care Association, providers' organisation for the independent care sector, London, 2 December 2008.
19. Age Concern England: London, 1 December 2008.

The Netherlands

Civil servants:

20. Ministry of Health – 1: Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport), Project Social Support Act (Project Wet Maatschappelijke Ontwikkeling), The Hague, 17 March 2008.
21. Ministry of Health – 2: Ministry of Health, Welfare and Sport (Ministerie van Volksgezondheid, Welzijn en Sport), Directorate for Long-term care (Langdurige zorg), The Hague, 22 December 2009.
22. Ministry of Social Affairs and Employment – 1: (Ministerie van Sociale Zaken en Werkgelegenheid), Regulation Personal Service Provision (betrokkene Regeling Dienstverlening aan Huis), The Hague, 18 March 2008.
23. Ministry of Social Affairs and Employment – 2: (Ministerie van Sociale Zaken en Werkgelegenheid), Labour migration, The Hague, 1 July 2008.
24. Ministry of Social Affairs and Employment – 3: (Ministerie van Sociale Zaken en Werkgelegenheid), Civil servant formerly involved with Law on Childcare, (betrokkene Wet Kinderopvang), 18 March 2008.
25. Ministry of Justice: (Ministerie van Justitie), Directorate Policy for Foreigners (Directie Vreemdelingenbeleid), The Hague, 1 July 2008.

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Interest group representatives:

26. Transnational Institute: Transnational Institute of Policy Studies, Amsterdam, 13 March 2008.
27. Abvakabo: Public sector trade union belonging to the Federation of Dutch Trade Unions (FNV), Leiden, 14 March 2008
28. Consultant childcare: Amsterdam, 18 March 2008
29. CFMW: Commission for Filipino Migrant Workers, Amsterdam, 21 March 2008
30. RESPECT: Network for migrant domestic workers, Amsterdam, 21 March 2008
31. Sting: Professional association for care workers, Utrecht, 4 January 2010.

Expert:

32. Botman: Sjoukje Botman, Amsterdam, 12 March 2008.

Phone interviews with randomly selected care providers in Amsterdam (January 2010):

1. Stichting Flevohuis
2. Puur Zuid
3. Stichting AMSTA
4. Cordaan Thuiszorg
5. Stichting Joods Maatschappelijk Werk

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