LONG-TERM CARE AND MIGRANT CARE WORK: ADDRESSING WORKFORCE SHORTAGES WHILE RAISING QUESTIONS FOR EUROPEAN COUNTRIES

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Summary: Long-term care (LTC) is highly labour intensive and will likely remain so in the future. Meeting growing demand for LTC from an ageing population will therefore depend on the ability to recruit and retain sufficient numbers of carers, whether in formal settings or within homes. Many European countries have responded to this challenge by employing a considerable number of carers from other countries, whether from Europe or beyond. This raises a number of important issues for policy and practice for both source and host countries, but social policies specifically regulating this type of service provision are rarely adopted.

Keywords: *Migrants, Carers, Workforce, Home Care, Long-term Care*

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Introduction

Long-term care (LTC) is highly labour intensive by its very nature and will likely remain so, even with advances in the use of assistive technologies. Meeting growing demand for LTC from an ageing population will therefore depend on the ability to recruit and retain sufficient numbers of carers, whether in formal care settings or within families. This presents a substantial challenge for many countries, given that jobs in the formal LTC sector are generally low paid and have a low social status, even though they require a high level of responsibility. Moreover, provision of informal care by family members of friends may become ever more

challenging given competing employment responsibilities, family obligations and changing family structures.

To address the challenge of insufficient care staff and inability to provide care within the family, many European countries employ a considerable number of carers from other countries, whether from Europe or beyond. Freedom of movement for labour between European Union (EU) countries opens doors for employing non-professional carers in households, often providing full-time care to older dependent people, resulting in increasing numbers of migrant carers. Care chains are observed, with workers migrating from central and Eastern Europe to Western Europe, but also globally from poorer to richer countries. Migrant carers can be considered in three groups: professionally qualified staff working in formal care agencies; carers employed by formal care providers; and carers employed by individual households. In some countries, carers employed by private providers and families may be unqualified while in others some level of qualification is required.

> social policies specifically regulating this type of service provision are rarely adopted

The increase of migrant carers' population raises a number of important issues for policy and practice. For destination countries, applying employment policies for migrant carers, assuring quality of care and enforcing adequate immigration regulations for carers from outside the EU are important challenges. For source countries, policy dilemmas are related to how to ensure that sufficient carers remain to care for their own older and disabled citizens requiring LTC. In these countries, the evolution of the number of available professionals, particularly with respect to nurses (e.g. Bulgaria), has been negative since the 1990s, with emigration and care drain as the main factors reducing the local health and care workforce.

The size of the migrant care workforce

The number of migrant care workers in Europe can only be easily assessed in Austria, as a result of the mandatory introduction of registries in 2007. In 2017, registry data show the overall number of migrant carers employed by households was approximately 70,000, which means that approximately 5% of beneficiaries of the care allowance were cared for by migrant carers.[1] In other countries only estimates are available. In Germany these range between 100,000 to 200,000 carers, mostly from Poland.[2] In Italy the official number in 2017 was 393,000 carers;[3] however, this figure does not include those providing household chores only (i.e. excluding personal care), who officially number 471,000, nor the large number of those working on an undeclared basis, which is estimated to reach 1.2 million.[4] In Poland, it has been estimated that every fifth migrant worker is a household worker, which would give a total number of about 100,000 migrant household workers,[5] including care workers, coming mainly from Ukraine.

Common trends in care migration in Europe

Migration related to care is a different phenomenon from migration in other sectors of the economy. It is strongly gender biased, with middle-aged females employed much more frequently than men. Most care migration is financially motivated due to poor wages, poor working conditions or inability to find a job in a home country. Sometimes it is an additional job, for instance through a contract with a temporary work employment agency, performed in turns with spells of employment in the source country.

In many countries, by being a household task, care by migrants remains undeclared work or even when declared, it is prone to being underreported due to high labour costs, long administrative procedures of migrant labour recognition or procedures related to visa regulations. Although it is rarely considered as a part of the LTC system, it is an important element of it and affects the system's sustainability.

Migrant care work in different long-term care systems

The participation of migrant care workers as domestic helpers is linked to the welfare system and particularly LTC services provision: the types of services available, types of benefits, their generosity and targeting. In countries with developed formal LTC systems and low or strictly targeted cash benefits, migrant carers are employed primarily in the formal care sector (e.g. England, France). In countries with more generous and unconditional cash benefits granted to older people with care needs (e.g. Germany, Italy) migrant care workers are frequently employed by private households.[6,7] Services provided by migrants complement available care services, lessening the pressure on informal carers (e.g. in Austria and Germany) and in countries with underdeveloped LTC they provide services which are otherwise unavailable, as the existing services are insufficient or target restricted population groups (e.g. in Poland).

Austria is the only country to designate some benefits specifically for employing migrant care workers, who are required to have certification to help assure service quality. In other countries (Germany, Italy), generous cash benefits create the potential for employing migrant carers, while falling short of formalising this care arrangement. In Italy benefits vary greatly between regions: in some they are very generous and not necessarily related to objectively assessed care needs, but allow for the employment of household help or a carer. Another incentive to employ a migrant care worker is created by tax relief on payments for this form of work in a household (Italy, Austria).

On the other hand, in England, while there are migrant care workers employed by households, their number is relatively small and not reflected in any official

statistics. There is no tradition of employing migrant care workers, nor does the LTC system support this option, as cash benefits are relatively highly regulated and less generous.

Recent policy developments in migrant care work

Migrant care work is a socially accepted segment of care, yet social policies specifically regulating this type of service provision are rarely adopted, with Austria and Italy being the only exceptions.

> There are risks of human trafficking and abuse

In Austria, subsidies to partially cover the cost of 24-hour care by registered migrant care workers have been introduced in 2007. Since the introduction of legal regulations in 2007, migrant care work has become an alternative to costly institutionalised services. Quality assurance measures have been introduced via certification requirements, training of care staff and quality monitoring. Introduction of the regulations allowed for monitoring the number and the flows (in and out of the country) of migrant carers. In fact, a market for services developed with brokering companies matching care recipients with care providers, although most regulated carers still operate as self-employed workers.

In Italy, the main policy objective (until 2012) with respect to migrant carers was to monitor the number of workers. This was done either *ex post* by checking and registering migrant care workers or by setting yearly quotas for them. However, this policy was abandoned in 2012 as a result of the migration crisis. Quality of care or working conditions are not subject to any regulations and monitoring at the national level.

Other receiving countries have not introduced similar policy measures.

Migrant care workers operate based on labour market regulations and the rule of free movement of workers between EU countries, which means either self-employment or working based on a contract with a brokering agency. In several countries, migrants can be legally employed by households (Germany, Italy and Poland). Sometimes, however, the work takes place in a 'grey zone' of the economy. The lack of regulation increases the risk of abuse of the carers and may affect the quality of services.

In source countries, migration related to care is also rarely a subject of policy debate. One exception to the lack of debate or regulation can be seen in Romania, where a regulation protecting Romanian citizens working abroad was enacted in 2017, although it is difficult to see how well or with what results it can be implemented. The policy debate related to migration in source countries, when it exists, concentrates on the brain drain threat for medical professions, particularly among physicians and nurses, where numbers are low and the profile is ageing.

Equity issues in migrant care services

Important equity issues arise with respect to the affordability of care and regulation of the market for migrant care services. Evidence points to inequity in the use of migrant carers across economic strata, with only wealthier families typically able to afford to employ a migrant care worker. In countries like Austria, Germany and Italy, where benefits (either specific subsidies for employing a migrant care worker or subsidies not specifically tied to this purpose) are available, care workers tend to be employed by people living in larger houses, with separate rooms for carers (particularly in the case of round-the-clock care). In Poland, where available cash benefits are low and insufficient to cover the costs of migrant carers' employment, services are obtained by older people and families with higher incomes, mostly living in large cities where family networks are more fragile.

On the supply side, inequities are related to the labour market structures within the country and the LTC sector as well as cross-border differentiations of employment and services regulations. In Austria, Germany and Italy, migrant care workers are typically employed in private household care, while native employees work in the formal care sector. There are inequities related to migrant workers' access to social security and labour protection, (particularly if the work is undertaken as temporary employment) and to wages and working conditions, as well as a risk of abuse.

Migrant care workers employed by households have limited access to social security and limited chances to improve their qualifications. Recent changes to family benefits in Austria have made child benefit amounts dependent on the place where the child is actually residing (although contributions are not similarly adjusted), in practice reducing payments for children of eastern European migrants (including EU citizens), unless they are also living in Austria. As many migrant carers legally employed in Austria rely on these benefits to supplement their wages, these changes are likely to further increase inequalities. Their work is rarely supervised and it is difficult for them to complain or seek redress in cases of mistreatment. In England, employment in care services is more equitable, with migrant care workers employed more frequently in the same positions as UK nationals, although wage differentiation can still be observed.

Another area of inequality is related to the cross-border activity and the role of employment agencies. There is still little comprehensive information on the mechanisms of the cross-border market for care services. Many migrant care workers are temporary workers: either self-employed or employed by a placement agency, typically a small one. Their work, although undertaken abroad, is registered as a domestic task in the source country and falls under domestic labour regulations concerning social security and the minimum wage; thus their situation is significantly different from the situation of other employees in the country they work in. In the case of temporary employment, their work falls under civil law rather than labour code regulations. As a result, the cross-border employment care sector is characterised by high level of uncertainty

and legal flexibility.[8] Research shows that even regularisation of the care services market – as in Austria – does not prevent problems with the quality of market services and employment.[8,9]

Challenges and opportunities related to migrant care work

Migrant care work can be perceived as an opportunity to overcome gaps in the LTC system as it lessens pressure on formal LTC to provide services to all dependent people. Supporting home-based care and reducing institutionalisation for people with dementia and high levels of incapacities and care needs is cost-effective (at the macro level), although the question of quality of care might arise. In the case of countries with low provision of LTC, migrant care supplements the insufficient supply of services in the public system. For the family, employing a migrant carer, although costly, is likely to lessen the psychological pressure on informal carers and might support their labour market reintegration. It is sometimes described as a 'win-win' situation: the family gains support, and the carer improves his or her financial standing, and has the opportunity to gain qualifications and experience.

Challenges related to migrant care work arise from the lack of integration with other LTC services and the lack of incentives to improve the system of LTC provision as long as care needs are being met by privately purchased migrant care services. In Italy, for example, migrant care provision is encouraged by generous cash benefits. Quality standards for care provided by migrants are in most cases not defined and difficult to monitor. There are risks of human trafficking and abuse although these should decrease with stricter controls of the operations of brokering agencies and monitoring of services. There are also challenges for the health and LTC systems of source countries (e.g. Poland, Slovakia and Ukraine). The outflow of migrant workers, which includes many medical professionals, brings more pressure to underdeveloped health and LTC system that already suffer from low numbers of medical professional due to poor wages and poor working conditions. These pressures are expected to increase, with these countries expected to be among the most aged populations in the coming decades.

Conclusion

While transnational care migration has grown in importance over the last decade with increasing number of migrant carers, there have been few policy changes with regards to domestic care work and available statistics generally fail to recognise the area. Issues, particularly those related to push and pull factors arising from the design of the LTC system in European countries, need to be addressed by policy measures. Inequities related to labour market structures, especially from a transnational perspective are another area where policy intervention may be helpful. Migrant carers need to be recognized in order to facilitate professional integration of care workers, improve quality of care and professionalize care work. In source countries, more attention should be given to policies preventing brain drain and improving formal LTC systems.

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