

**Migrant family carers in Austria and Germany:
Policy fields, policy development and their interplay**

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Abstract

During the 1990s Austria and Germany established new long-term care schemes to provide support in situations of care dependency. In both countries, the schemes are designed to combine universalism and cost-containment policies, which resulted in the creation of a new, country-specific type of universalism. Recently, in both countries migrant carers have emerged providing care within the family context. The development, which inspired the introduction of new regulations, can be explained by the new type of universalism established in the long-term care schemes. Against the background of the emergence of migrant care work in both countries, the paper aims to analyse the processes of policy development related to the introduction of the long-term care schemes and regulations of migrant care work and their interrelationships. It proceeds by the assumption that the analysis of the processes of policy-making does not only explain the construction of the policy-designs, but also reveal the interrelationship between the policy fields.

The paper combines several conceptual approaches. Concepts created within international comparative research on elder care policies provide with the analytical tools to define the content of long-term care policies, in particular the type of universalism. New-institutionalist approaches with their emphasis on ideas, actors and institutions are used to exam the policy processes. Finally, research on processes of Europeanization and transnational policy transfer is included to analyse cross-border impacts. The findings show the complex interrelationship of ideas, actors and institutions in the different policy fields and the related dynamics. Germany and Austria are selected as two case studies relevant to the processes on policy development in both fields, however, with distinct patterns. The data sources include information on policy designs, on processes of policy development as well as statistics and research findings on the care situation.

1. Introduction

Since the end of the 1990s, in Austria and Germany a new pattern of care arrangement have gradually become visible: Migrant carers providing 24 hours care within the family context. The new pattern of care arrangement emerged embedded in the interplay of different policy fields related to long-term care. First, with the introduction of long-term care schemes in the 1990s a universal scheme was established within a framework of cost-containment policies. The goal to combine universal support with cost-containment policies resulted in the creation of a new, country-specific type of universalism based on a certain mix of public-private responsibilities. The institutional design, the underlying ideas and the outcomes of the schemes furthered the emergence of a new pattern of care arrangement; i.e. care provision within the family context by migrant carers as a form of bottom-up development. The bottom-up development by care users or their families inspired intense political debates and efforts to legalise and regulate the working situation in both countries.

The paper aims to examine the processes of policy-development related to the introduction of long-term care schemes and the regulations of migrant care work and their interrelationship. It proceeds by the assumption that institutional designs, underlying ideas and outcomes related to the the long-term care schemes are not only strongly related to the

emergence of migrant carers but also to the construction of policies regulating migrant care work. Thus, the analysis of processes of policy-making contributes to the understanding of the interrelationship of both policy fields. The long-term care schemes and in particular the country-specific definition of universalism were created by the interaction of politicians on different levels and societal actors within each country. In addition, transnational policy transfer, i.e. scientific evaluations of foreign care schemes impact on the construction of the schemes within the countries. The emergence of migrant carers is strongly related to the type of universalism defined in the long-term care schemes and the resulting care gap. Comparable political and societal actors are involved in the processes of domestic policy-making related to migrant care work, while cross-border effects are intensively discussed and provide a framework for domestic policies.

In order to analyse the processes and results of policy-making the paper combines approaches set up in international comparative welfare state research (see section 1). Concepts established within the area of elder care are used to define the dimensions of universalism necessary to show the new type of universalism. Findings and concepts developed within research on Europeanization and transnational policy transfer are included in order to analyse cross-border impacts. New-institutionalised approaches, which emphasise the interplay of actors, ideas, interests and institutions, provide the tools to examine the processes of policy development.

Empirically, Austria and Germany are selected as cases, where both processes of policy-making can be found, i.e. the establishment of a universal long-term care scheme and regulations related to migrant care work. The case studies aim to reveal the interrelationship of the policy fields from the perspective of the content of the policies and the processes of policy development. Despite cross-border impacts, policy-making continues to be defined by domestic actors.

1. Conceptual framework

1.1 Universal long-term care policies: Institutional design and ideas

At the beginning of the 1990s, in both countries a universal-oriented long-term care scheme was introduced related to cost-containment policies, which resulted in the definition of a new type of universalism. Basic dimensions of institutional designs of long-term care policies enable to analyse this new type of universalism respectively the underlying mix of public-private responsibility. Based on elder care research four basic dimensions of policy designs –

eligibility criteria, range of risks covered, level and type of public support – can be summarised and used as analytical tools. Dimensions of institutional designs are strongly related to ideas on long-term care and outcomes for people in need of care (overview see table 1). In the section dimensions of institutional designs and underlying ideas are discussed as basis for the empirical analysis of processes of policy development, while the outcomes are outlined after the analysis of the policy process (see sections 2.1.2 and 2.2.2)

Eligibility criteria and the range of risks covered determine access to public benefits and thus provide a first definition of public responsibility. The range of care risks covered, e.g., bodily care, household and social services, institutional care provision, and the level of care needs, serve to define the threshold for public support. Benefits can be granted universally or according to economic circumstances (ascertained by means-testing) and/or depending on the family situation (Anttonen et al 2003).

A second definition of public responsibility is related to the level of public support, which determines the mix of public funding and the private/family resources required. Österle (2001) summarised ideas determining the level of support and related them to policy goals. The first goal of care policies “guaranteeing minimum standards” aims to prevent care recipients falling into poverty and provides only a minimum level of public support. The second goal, “supporting living standards”, grants a higher level of public support to prevent older adults from big drops in their individual living standards.

The types of benefits available can be viewed as a third definition of the private/public mix. Different types of benefits have been introduced in care policies, such as cash benefits, services or leave arrangements, which deliver money, services and time for care recipients and informal carers (Daly, 2000). The different types of benefits reflect the ideas of an ideal combination of formal and informal care provision. While time is provided to support care within the family framework, money enables care recipients or family members to choose whether to provide care themselves or to organise provision. Finally, the expansion of care services aims at developing professional care offers for care recipients, unburden family carers or to secure quality standards.

The dimensions of institutional designs are related to ideas of a “good” care provision and adequate mix of private and public provision and funding. They are of particular significance in the process of framing of the policy issues. Related to the new type of universalism the following ideas proved to be decisive (see e.g. Pfau-Effinger 2004; Clarke et al. 2005).

- the definition of public responsibilities
- the mix of different societal sectors – state, market, family, civil society – with regard to care provision and funding
- the role of choice and autonomy of users

1.2 Policy-development: National and transnational frameworks, actors and ideas

Traditionally, long-term care policies were developed and implemented at local levels, but increasing public responsibility within the area has restructured the interplay between central, regional and local levels (Anttonen et al., 2003). The central-local-regional interplay within countries also becomes crucial in the course of policy development. Political institutions on different levels and their interplay define the mode of vertical (de)centralisation, structure processes and results of policy development in a multi-level system (Rauch, 2005; Burau et al., 2007, Ranci, 2007). Since the 1990s, numerous empirical studies have investigated into the role of divided decision-making between different political levels on welfare state restructuring. In general fragmented structures between central, regional and local levels provided to be a negative precondition for welfare state changes, because they provide actors with institutionalised veto-points to obstruct governmental reforms (see e.g. Immergut 1992; Rauch, 2005).

Despite the significance of processes of policy-making within the countries, the development of long-term care policies are in addition influenced by cross-border effects. This concerns processes of policy transfer between countries as well as the impact of supra-national entities such as the EU (Theobald/Kern, 2009). In western Europe, social policy developments are characterised by long traditions of cross-border interaction and cooperation embedded in comparatively well-developed systems of policy transfer between countries. Processes of policy transfer are made up of intense cross-border exchanges on different levels among experts, researchers, politicians, administrators and civil organisations on concepts and outcomes of welfare state policies (Kaelble, 2005). Thus, policy transfer necessitates networks of stakeholders on the political and administrative levels, as well as within civil society that facilitate the adoption of foreign models to national conditions (Kaelble 2005; Radaelli, 2006). Particularly in a situation where different states may be searching for solutions to the same policy problems, a willingness may be prompted to emulate other countries` policies (Bulmer et al., 2007).

A second form of impact on the development of long-term care policies is related to EU-policies. Here, the complex and restricted patterns of opening-up the borders between the old and new EU-member states can be pointed out. It enables citizens of the new member states to enter the territories of the old member states, but in some old EU member states, e.g. as Austria and Germany, restrict access to the regular labour market until 2011. Moreover, EU regulations related to freedom of movement for capital, goods, services and labour to strengthen the EU's single market goal, have gained in significance. In clearly defined situations the regulations allow – mainly temporarily – the provision of some type of services or work activities in the old member states by citizens of the new member states. Here, EU-regulation focuses on discrimination between residents and non-residents and on measures to dismantle barriers to trade and freedom of establishment (Radaelli, 2006).

National and transnational institutional regulations provide the framework for processes of policy-making. New-institutionalist approaches view policy changes as the result of the interplay of actors and their ideas within the framework of institutional regulations and political institutions. Ideas are particularly significant during the process of framing of a policy issue in situations of high uncertainty, when existing structures are less likely to determine the behaviour of key political actors (Pierson, 2004; Brodin, 2005 for elder care). Ideas, however, only become politically influential when they interact with powerful political actors or coalitions and are embedded in institutional frameworks that create opportunities for certain actions (Thelen, 2004; Beland, 2009).

Research on policy development related to long-term care policies reveals certain specificities of the field, in particular concerning the role of actors and institutional frameworks. Burau and colleagues (2007) point out that the policy issue of long-term care does not easily fit into the public nature of policies precisely because home care stretches across the private/public dichotomy which weakens social actors. The fact that numerous actors have interests – especially with regards to the risk of care dependency – opens up the possibility of alliances between different groups that render reform possible despite the weakness of the new risk bearers themselves. This produces a diverse range of actors, including some operating from the outside, such as patient advocacy groups, and actors operating on the inside. Reform processes generally tend towards programmes favoured by the political actors who are able to exert the most influence (Taylor-Gooby, 2004).

2. Empirical section: The interrelated development of long-term care policies

Empirically, Austria and Germany are selected to examine the processes of policy development of the new long-term care scheme and the introduction of regulations related to

migrant care work. The combined analysis reveals the interrelationship between both policy fields, i.e. the content of the policies and above all the processes of policy development. Despite the fact that both countries can be defined as corporatist and federalist systems the results of policy development processes vary widely owing to the impact of certain social actors and their ideas. The following case studies compare the interplay of actors, their ideas and institutional frameworks in the process of policy-making between both countries. The analysis includes interactions between actors within the national context and cross-border impacts.

2.1 Long-term care schemes and the regulation of migrant care work in Austria

2.1.1 The introduction of the Federal Care Allowance in Austria

In 1993 a care allowance scheme was created by federal law in Austria. Up until then, the public support system in Austria was characterised by a decentralised responsibility for care support, cash benefit structures, and home-based and residential service offers (Da Roit et al., 2008). The 1993 reform incorporated two main parts. A universal oriented allowance valid in the entire country was introduced to guarantee access to cash benefits for care users on the basis of defined levels of care needs. Beneficiaries can use these benefits to either purchase professional home-based services, organise care provision autonomously or to move to residential care facilities (Pacolet et al., 2000). In addition, the federal states promised to expand care services to meet demand for professional care until 2010 (Da Roit et al., 2008; Egger de Campo, 2008).

The risk of care-dependency has been to the fore in the societal debate since the beginning of the 1980s. During the 1980s the increasing costs for care provision for the federal states resulted in their demand to transfer costs to the central level, which provide a major incentive to develop a national scheme. A wide range of political actors on central, federal state or local levels, representatives of disability and pensioners' organisations, as well as welfare and professional carers associations were involved in the process of policy development (Behning, 1999).

The care allowance scheme is oriented towards care-dependent elderly adults, as well as to people in need of support due to disability. The disability movement, in particular, was instrumental in shaping the design of the care allowance system. During the 1980s Vienna was made the centre for the coordination of the UN's worldwide activities relating to the situation of disabled people. The consequent pressure on the Austrian government to introduce well-adapted policies for disabled people offered relevant organisations

considerable leverage to influence the ensuing stages of policy development and policy design (Behning, 1999).

Initial debates were dominated by the question of the type of benefit, i.e. cash benefits or in-kind services. The representatives of the disability movement, together with those from the conservative, liberal and green parties, voted for the introduction of a care allowance scheme to enable an autonomous life on the basis of self-organised care provision. In the course of the discussion the emphasis was on the situation of the care users, while the working-conditions of the self-organised carers received far less attention. Only the chamber for blue-collar workers opted for the expansion of service provision based on standard employment at the beginning. The Social Democratic party supported a mixed system of cash payments and services (Behning, 1999).

In addition to the disability movement the federal states were decisive for the establishment of a care allowance. The council of the federal states, which had to approve the scheme, was dominated by conservative governments with a majority in favour of a care allowance scheme. In particular, Tyrol and Vorarlberg – with already established care-allowance systems – strove to establish a similar, central-level model (Behning, 1999).

The care allowance scheme aimed not only to give more autonomy to users but to lower the costs of care provision. The new scheme was to provide universal support but relate it to cost containment policies. The disability movement argued for comprehensive benefits to cover the costs of long-term care, but it was considered too expensive (Behning, 1999). A comprehensive service-oriented system, like that in force in Nordic countries, was also considered too expensive in a time of welfare state constraint (Amann, 1994).

During the debate the mainly uncovered risks of care dependency were defined as a European problem. Research projects were conducted on behalf of the Ministry of Social Affairs to evaluate care allowance schemes in other European countries (e.g. Evers et al., 1993). Comparative studies with the Nordic approach concluded that, even in Sweden, the introduction of a combination of cash benefits and services was on the policy agenda to establish a sustainable system (Baldock/Evers, 1992; Evers et al., 1993).

Finally, in 1991 the Ministry of Social Affairs and representatives of the federal states approved the introduction of a universal care allowance scheme (Behning, 1999). Within the law no regulations were defined concerning the social security, working situation etc. for the self-organised carers on the basis of the cash payments (Da Roit et al., 2008). In a next step

the discussion on the mode of funding intensified. Due to the increase of pay roll taxes the social partners rejected a social insurance scheme. Federal states demanded that the costs for allowances be covered mainly on the federal level. In the end, the federal government decided to establish a mainly tax-based scheme with only a small part of social insurance funding, and to cover the costs for allowances mainly by the federal tax budget. After the level of cash benefits had been legally defined it was criticised as not providing sufficient means to purchase care services (Amann 1994; Behning, 1999). In contrast, a full-funding system was viewed as illusory (Kytir/Münz, 1992).

2.1.2 Migrant carers: Interrelationship of policies fields

The emergence of migrant workers in care provision within the family context is strongly related to the institutional design of the allowance, the underlying ideas and the outcomes. By international comparison, Austria's universal-oriented cash allowance – with 18% of the 65+ qualifying – is high among the elder population and supports a significant share of recipients with minor care needs (see table 1). Based on ideas of a certain mix of public and private responsibilities, an emphasis on care provision within the family network and on the autonomy of the users certain policy designs have been constructed. Only a lump sum benefit is granted, which must be complemented by private means or informal family care. The frequency of home-based service provision is quite low and mainly supports basic care provision. This results in a largely family-oriented home-based care system with informal care and a range of semi-formal and grey-market activities. The use of institutional care in a situation of high care dependency entails considerable private costs (Schmid, 2009). Unregulated cash payments on comparable high levels independent of the type of care provision provide an incentive for the use of grey market labour within the family framework.

Since the end of the 1990s, the care gap mainly related to comprehensive care needs and the availability of unregulated cash benefits resulted in the emergence of a new segment of the grey market: the provision of 24-hour care within the family context by migrant workers mainly from Eastern European countries, i.e., the Czech Republic, Slovakia or Hungary. The opening-up of the borders to eastern European countries after 1989 contributed to its emergence. EU enlargement in 2004 enabled the citizens of the new member states to legally enter the old EU member states, but their access to the regular labour market is restricted in Austria until 2011. According to estimates between 28,000 and 30,000 migrant carers deliver 24-hour home care services in about 15,000 households in Austria (Schmid, 2009). Migrant carers are mainly hired by severely frail older adults or their families. Care arrangements are motivated by lower private costs compared to 24-hour formal home-based

care provision or residential care, and the wish to stay at home or close to the family despite a severe level of care dependency (Schmid, 2009).

This bottom-up solution launched an intensive societal debate and resulted in the introduction of a scheme to legalise migrant care work within the family context in 2007. Judgements defining the existing care provision within the family context as illegal and the care scandal during the 2006 general election campaign, with high ranking politicians employing illegally migrant care workers, provided the starting-point for legislation policies (Schmid, 2009). During the process of policy development the idea of expanding existing professional care provision was rejected for cost reasons. The migrant carer regulation was defined as the prime goal by all negotiators, while the legal form to be introduced was controversial (Egger de Campo, 2008; Schmid, 2009). While the representatives of the Chamber of Commerce voted for a model of self-employed carers only, the Social Democratic Party opted for the introduction of regulations related to an employee status within the family framework. The unions and the Chamber of Blue-collar Workers suggested a model whereby the carers would be employed by home-based service providers and publicly subsidised. The Conservative People's Party focused on the development of different types of regulations related to freedom of choice (Rudda/Marchitz, 2006). The debate centred on the situation of care-dependent older adults, while the disability organisations were only rarely involved. They had already managed to establish different personal assistant systems on federal state level (Prochazkova/Schmid, 2007)

The law combines the different suggestions of the social actors and relate it to freedom of choice for the users. It offers three alternative modes of regulating the employment of migrant care workers within the family context (see Schmid, 2009). Namely,

- the status of a self-employed live-in carer
- the status of a carer employed by the family
- the status of a carer employed by a welfare association
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The law can be used by care recipients assigned to at least level-three care-dependency within the framework of the Care Allowance. The working regulations differ widely for each status. To cover the extra cost to families for the mandatory social security benefits, users with a monthly income of €2,500 or less receive the entire amount to cover the costs of social insurances and taxes. By autumn 2008 the working conditions of 14,000 migrant carers had been legalised. Almost all families chose the self-employed status, i.e., the cheapest alternative that nevertheless enables them to receive 24-hour care provision (Schmid, 2009).

This result was strongly criticised by the welfare associations, unions and the Chamber for the Blue-collar Workers. It is viewed as a risk for the development of standard employment in healthcare provision and a disadvantage to formal care provision. Nonetheless, the cost argument – to lower the cost for the public system – prevailed because it was considered more significant (ÖKSA 2008).

Table 1: Long-term care schemes: Ideas, institutional designs and outcomes

	Austria	Germany
Ideas - Responsibility - Family/service provision - Autonomy of users	Public-private-mix Family-oriented care High	Public-private mix Family-oriented care Medium, quality control
Institutional designs - Eligibility criteria - Range or risks - Type of support - Level of support	Universal Bodily care, household, social services At least: 90min.need, p. day Cash payments Defined lump sum	Universal Bodily care, household, social services At least: 90min. need p. day, additional criteria Mix: Cash payments, home-based, residential services Defined lump sum
Outcomes (2004) - Coverage Beneficiaries: Share 65+ - Range of risks Level: below 300€ p. month Share beneficiaries - Type of support Home-based care Share beneficiaries Residential care Share beneficiaries 65+ 24h migrant care Share beneficiaries - Level of support Home-based services Residential services	18% 56% 29% 15% 3.6% 4-5%	11% (2005) 28% (2005) 38% (2002) 30% 3.4% 3-4%
	Low frequency High private costs	Low frequency High private costs

Sources (outcomes):

Schneekloth, (2006); Huber et al., (2006); Federal Statistical Office (2007); Neuhaus et al., (2009), Schmid, (2009)

2.2 Long-term care schemes and the regulation of migrant care work in Germany

2.2.1 The introduction of the Long-term Care Insurance

Together with universalism, cost containment was the main goal pressed with the introduction of Germany's long-term care insurance (LTCI). A societal debate on exposure to the risk of care dependency had been on-going in Germany since the end of the 1970s. The increasing costs for residential care at municipal levels provided the main incentive in 1995/96 for the establishment of a new pillar within the German social insurance system (Campell/Morgan, 2005).

On the basis of defined levels of care-dependency related to a considerable level of care needs LTCI covers universal support based on cash benefits, home-based and institutional care service provision (see table 1) In contrast to Austria, the debate in Germany was dominated to a wide extent by discussion about the mode of funding. Based on this, the mode of public support for an adequate mix of professional and informal, family care was subjected to intense debate.

A wide range of interest groups were involved in the development of this policy, including the government and opposition in the federal parliament, representatives of the federal states and from local levels, social partners, welfare associations, health insurance funds and civil society organisations, such as the pensioners and disability organisations (Behning, 1999; Meyer, 1996). As in Austria, the social actors viewed the policy issue in a European context and the situation and policy approaches in further countries were examined and discussed (Meyer, 1996).

At the beginning of the policy development process, the introduction of a social insurance scheme, compulsory private insurance schemes and, more rarely, the introduction of a tax-based system were contrasted (see Meyer, 1996). The Liberal Party in office with the Christian Democratic Party on the central level, the federal state Baden-Württemberg and the employers' organisations favoured a private insurance solution emphasising individual responsibility. The Christian Democratic Party, the Social Democratic Party as well as the majority of the social democratic dominated council of the federal states and the unions opted for a social insurance solution. A working-group was set up during the process of policy-making with (social democratic) members of the council of federal states and representatives of the federal Ministry of Social Affairs. In the end, the Liberal Party agreed

to a social insurance scheme under certain premises. For example, employers had to be compensated for their share of the contribution with the abolishment of a bank holiday, which meant a considerable departure from the German social insurance system (Landenberger 1994).

The social insurance scheme was established to provide universal benefits for people in need of care, although the granted lump sum did not aim to cover the needs comprehensively, but needed to be supplemented by private means or informal care delivery. At the beginning of the debate most of the political and civil society actors involved argued that the funding level for long-term care should be comparable to the comprehensive funding level for health care. In the end, however, the more economically-oriented actors from all political parties prevailed. High expenditures and insurance contributions in the Netherlands, in particular, and the high public expenditure related to the health care insurance in Germany were recognised as indicators of the financial obstacles of a more comprehensive social insurance scheme (Meyer, 1996).

The provision of “in-kind services only”, comparable to the health care insurance scheme, was rejected by almost all actors, as not coherent with the reality of care provision where family members, friends and neighbours contribute. In particular, the health insurance funds – from a quality perspective – and partly the unions opted for a more service-oriented system (Meyer 1996). As in Austria, the costs related to in-kind benefits only were judged to be insupportable. Civil society organisations, welfare associations and market-liberals advocated the introduction of cash payments only to increase the autonomy of beneficiaries – albeit on different levels. Most of the actors – including members of the Christian Democratic and Social Democratic party- voted for a mixed system with cash benefits to acknowledge informal care provision and care services to guarantee high-quality care. Finally, long-term care was defined as being provided by a combination of informal family care, professional home-based and institutional care. A corresponding mixed system of public benefits – a cash benefit on a lower level to acknowledge family care provision but to avoid the “economisation of family care” and higher benefits oriented towards the more costly home-based and institutional services – was introduced. In addition, the higher benefit related to the use of institutional services aims to reduce the dependency of the beneficiaries on complementary social assistance benefits (Meyer 1996).

2.2.2 Migrant carers: Interrelationship of policy fields

As in Austria, the emergence of migrant workers in care provision within the family context can be explained by the design of the long-term care insurance, the underlying ideas and the

outcomes (see table 1). Comparable to Austria the scheme is based on certain ideas on the mix of public private responsibility and an emphasis on care provision within the family framework. In contrast to Austria, the role of autonomy of the users is less pronounced, while the significant role of the families in care provision and the importance of care quality was emphasised. Within the mix of ideas the policy designs have been constructed. Despite the orientation on universal benefits on the type of care provision chosen, the provided lump sum benefits require either additional private means to purchase the necessary services or (complementary) informal family care. This has resulted in a largely family-oriented home-based care system, where the frequency of home-based service provision is quite low and concentrated on the support with bodily care provision. The use of institutional care entails considerable private costs for beneficiaries and their families (Schneekloth, 2006). Two differences between the countries can be stated. First, compared to Germany in Austria public support is already available with minor needs. Second, the orientation of the level of benefits towards the type of care provision, may explain the lower proportion among the elder in Germany using migrant care services within the family framework.

Despite the country differences, since the end of the 1990s also in Germany a new segment on the grey care market has emerged; the provision of 24-hour care within the family context by migrant workers mainly from Eastern European countries, i.e., the Czech Republic, Poland and Romania. As in Austria, the opening-up of the borders to eastern European countries after 1989 and the restricted access of citizens of the new EU member states to the regular labour market in Germany contributed to this development.

According to estimates about 100,000 migrant carers deliver 24-hour home care services in about 50,000 households in Germany (Lutz, 2009). Migrant carers are mainly hired to take care of severely care-dependent older adults on higher income levels. Families with migrant carers cite the lower private costs for care compared to 24-hour formal home-based care provision or residential care. The monthly costs for 24-hour care organised by an agency lie between €1,200 and €2,400, while the costs for privately organised provision may be lower. Such care arrangements are further motivated by the wish to live in one's own home despite a high level of care dependency and to relieve the burden on family carers. (Neuhaus et al., 2009; Lutz 2009).

In Germany the bottom-up solution established mainly by middle-class families caused an intensive societal debate and inspired new policies to regulate the situation. A legal recruitment scheme was implemented to hire domestic workers to families with care dependent members from eastern European countries already in 2002, on a temporary basis

until 2005 and thereafter permanently. The introduction of the new policy scheme was accelerated in the aftermath of a police raid, when migrant workers from Eastern European countries were found in approximately 200 households (Shinozaki, 2009). The regulations that were subsequently set up agree with regular working-conditions in Germany, and must comply to labour laws and social security standards. The monthly costs for a household lie between €1,500 and €2,000. According to the authority responsible for placements, 3,032 domestic workers were officially employed on this basis in 2007, which can be compared to grey market care with about 100,000 migrant carers providing care within the family context (Lutz, 2009).

Moreover, regulations related to the single market project are often used to legitimise this type of care provision. The right of free movement for services within the single market project (Article 49 EU treaty), which allows the temporarily provision of services on a self-employed basis, has been often brought forward. However, in November 2008 the local court in Munich defined the practice as illegal due to the non self-employment character of the activity, such as e.g. service provision to one customer only and imposed a fine on the broker (a ruling confirmed by the higher regional court in Bamberg in 2009). In his motivation the judge in Munich expressed his understanding for the difficult situation of the families and requested that clear-cut regulations be created. The Posting of Workers Directive of the EU is also put forward as a legal basis (Directive 96/71 EC). According to the directive it is possible for companies to offer temporarily services in further EU-countries. In principle, the customer in Germany pays the company for the services delivered, while the company pays wages and social security benefits for their employed carers. In reality, it is often arranged by agencies. According to the law, customers in Germany are obliged to follow Germany's labour laws, e.g. related to working-hours but these do not fit well with 24-hour care arrangements (Caritas, 2006; Neuhaus et al., 2009; Steffen, 2009).

This largely illegal situation in Germany is an open secret but it is also – covertly – accepted as it is recognised that it reduces public expenditure for residential care provision (Lutz, 2009). The majority of influential actors continues to demand that an affordable legal service offer be introduced and are opposed to legalising current practice. Recently, however, diverse Protestant and Catholic welfare associations have demanded that the situation of migrant care workers be regularised and have proposed that cooperation in daily care work be established between professional and migrant carers (Neuhaus et al., 2009). At the federal state level, politicians are endeavouring to establish further legal but low-cost care offers, e.g. by recruiting voluntary workers and care workers on the basis of legal, but low-standard working-contracts and to subsidise private costs (cf. e.g. Ministry for Labour, Social

Affairs, Family and Health Rhineland-Palatinate, 2006; Ministry for Labour and Social Affairs Saarland, 2009). There is no indication that a legislation policy is on the horizon. Nor is there any indication of the establishment of a sufficient formal care provision that is affordable.

3. Conclusion: Interplay of policy fields – actors, ideas and institutional designs

In the focus of the paper is the analysis of the interrelationship of two policy fields – long-term care schemes and regulations related to migrant care work. It includes, both, the institutional design, ideas and outcomes of the policies as well as the processes of policy development. It is based on the assumption that the analysis of the interaction of actors, their ideas and institutional frameworks during the process of policy-making do not only explain the design of the policies established but reveal the interrelationship of both policy fields. Austria and Germany have been selected as two cases, where both developments and their interrelationship can be examined empirically. Theoretically, the paper combines concepts and assumptions developed within different areas of international comparative welfare state research.

At the beginning, the paper examines the development of universal oriented long-term care schemes within a framework of cost-containment policies. In both countries despite universal access, cost containment should be achieved, first, by the definition of the level of support – which leaves a considerable amount of private responsibility – second, by the introduction of unregulated cash benefits, which are insufficient to pay for formal care provision, and, third, by the definition of certain thresholds of care needs. In both countries, fiscal problems on regional or local levels provided an incentive to demand the introduction of a new scheme on central levels. The schemes were defined in close cooperation between politicians on central, regional and local levels, as well as social actors. The design is based on ideas on the role of certain sectors with regard to care provision and funding, in particular the role of the family, the level of public responsibility and the role of the users. Based on different policy goals and the involvement of different actors the designs of the policies differ between the countries. In Austria, due to the influence of some conservative federal states and the disability movement with its emphasis on autonomous care provision, a care allowance scheme was introduced, although not the comprehensive cover for which the movement campaigned. In Germany, the need to raise new funds for care provision set the mode and level of funding firmly at the centre of the debate, while the mix of benefits introduced can be viewed as a compromise between different goals. In both countries, the idea of only partial public funding – with considerable private responsibilities – was meant to achieve cost containment. Two types of cross-border impact can be found. The UN with its emphasis on

the situation of disabled people offered their organisations in Austria wide scope to act. In both countries, expert reports on care policies in other countries are used by actors to strengthen their own arguments.

In both countries, designs, underlying ideas and outcomes of the schemes led to the emergence of migrant carers within the family network as a way to close the care gaps. Unregulated cash benefits enable the hiring of carers working under legal or illegal agreements. The more generous cash benefits in Austria may explain the higher proportion among the elderly using this type of care provision. This bottom-up solution inspired a political debate and the introduction of regulations embedded in the framework of the design of the long-term care scheme and the underlying ideas. In Austria, a new scheme has been installed, which aims to legalise migrant care work within the family framework by the establishment of an employment situation far below the national standards. The regulations combine ideas of the necessity of cost-containment policies, the emphasis on family care and autonomy of the users as well as the neglect of the working-situation of the carers already prevalent in the course of the construction of the long-term care scheme.

In Germany, two types of regulations are used. First, the government introduced a recruitment scheme for domestic workers, which correspond with regular labour market standards albeit on a low level. The scheme is only rarely used. EU-regulations related to the single market project are put forward to legitimise this pattern of care provision. However, judgements in Germany revealed that – despite the EU regulations – working conditions were not in accordance with the country's national labour laws. While in Germany some actors, such as welfare associations, have recently demanded a legislation policy for migrant carers, politicians are still not openly interested in a regulation. No legislation policy and no efforts to increase service provision effectively are on the horizon. The distinction between paid care provision based on regular – albeit – low labour market standards and symbolically paid informal care by family members prevalent in the German debate may offer one explanation for the country differences.

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