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**FILLING THE GAPS:
MIGRANTS AND CARE WORK IN EUROPE AND NORTH AMERICA**

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This paper explores the hypothesis that there is less demand for migrant care workers in societies with strong welfare states and well-supported provisions for children, the elderly, and those with disabilities, than in societies with weaker welfare states, where such services are poorly or not supported and/or left up to families or the market. A sub-hypothesis is that even in strong welfare states, the *type* of provisions matters: in states with largely formalized, institutional, and professionalized services, there is less demand for migrant workers than in states with informal “cash-for-care” schemes.

Many theories and models have been advanced to explain the growing demand for migrant care workers in the global North. Some focus on “facts on the ground”-- increasing populations of ageing people and children needing care in families where all other adults are employed outside the home (the so-called “adult-worker family), while others invoke institutional factors such as the laws governing migration and policies organizing care. The causal significance of demographic and employment statistics is undeniable, particularly since they are relatively uniform across the societies in which demand for care workers has increased. But levels of demand and the ways in which they are met vary, and in order to explain this, we must look more closely at institutional and structural factors. Here the most compelling theory has been offered by Fiona Williams (in Lister et al. 2007, chap. 5; and Williams 2010), who argues that demand is shaped through the intersection of migration, employment, and care

regimes. By calling for a multi-factor analysis, Williams is implicitly broadening out Gøsta Esping-Andersen's (1990) "welfare state regimes" paradigm in useful ways—ways that I will attempt to take on board in this paper.

The hypotheses for this paper were initially formulated before I read Williams' latest work and thus echo the narrower conception of welfare state regimes that has prevailed for some time. My principal hypothesis was the following: there is less demand for migrant care workers in societies with strong welfare states and well-supported social provisions for children, the elderly, and those with disabilities, than in societies with weaker welfare states, where such services are poorly or not supported and/or left up to families or the market. I also offered the sub-hypothesis that even in strong welfare states, the *type* of provisions matters: in states with largely formalized, institutional, and professionalized services, there is less demand for migrant workers than in states with schemes such as "cash-for-care," which devolve the task of organizing care and hiring workers to families or, in the case of elders, to the individuals needing care, and thus tend to produce informal arrangements.¹ In what follows, I explore these two hypotheses but, taking a cue from Williams, I also consider the role of migration and employment regimes in producing demand.

Care regimes comprise a number of different components, both structural and cultural, which can be disaggregated analytically but often turn out to be intertwined. In terms of their structural characteristics, care regimes are often distributed along a spectrum from familial to institutional according to particular patterns of how care is organized, who provides it, and how it is financed. The organization of care ranges from in-home arrangements (whether by family members or employees hired individually or through commercial or voluntary staffing services) to cooperative, collective or group services provided through institutions run by states, voluntary

organizations, or commercial firms. Providers range from family members to unskilled or semi-skilled workers to professionals, with credentials (or lack thereof) to match, and from private employees in an informal market to public or regular employees in a formal market. Services may be unpaid and/or self- (that is, client-) financed; state-subsidized, either partly or wholly, through “cash-for-care” schemes, care allowances, or the like; directly financed by states, or for-profit.² Similar spectrums may be found across domains of care, whether for elders, children, or the chronically ill and persons with disabilities, but structures of care are not necessarily uniform across these domains in any one society; that is, in a single case, elder care may be predominantly informal while child care is highly organized, or vice-versa (see Appendix).

To some extent, the familial-to-institutional spectrum may be aligned with Esping-Andersen’s (2000) original typology of liberal, conservative/corporatist, and social democratic welfare state regimes, but because policies and practices are often admixed and also rapidly changing, the two do not match perfectly (Appendix). The spectrum might also be characterized as ranging from private to public, but this, too, would be misleading, since, as I argue below, the seemingly private nature of individual, in-home arrangements is still an effect of public policies, albeit perhaps those that are *laissez-faire* or neo-liberal, and of political deliberations that either produce such arrangements *de novo* or leave them intact. Nevertheless, both typologies are useful in thinking about how and why specific care regimes produce certain levels of demand for migrant workers.

The cultural components of care regimes include what analysts call “cultures”—or “ideals” of care (Kremer 2007). This concept refers to widely held assumptions about what types of care are appropriate for particular groups—e.g. children or elders—and who should provide it. Cultures of care are seldom all-determining, but they may work to shape care regimes through

political processes, or result from existing regimes in the form of “policy feedback” (Skocpol 2002; Pierson 2003). As we shall see, the first mode is characteristic of traditional societies with strong familial ideals that often hold sway in public debates, while the second appears frequently in social democratic societies whose prominent public services produce powerful allegiance—policy feedback.

It is important to note, however, that cultures of care are not permanent but can shift in response to changing conditions—social, economic, and especially political. As with structural characteristics, cultures of care may not be uniform across care domains within a particular society; that is, care by non-family members may be considered acceptable for elders but not for children—or vice-versa. Cultures of care may also be reinterpreted to rationalize new structures of care under changing conditions.³ For example, as I discuss below, in cases where traditional caregivers--adult women—increasingly move into the paid labor, families adapted by hiring migrant workers to provide in-home care and rationalize this practice by saying that workers are “like one of the family.”

According to my initial hypotheses, I expect to find the greatest demand for migrant care workers in tradition-bound societies with weak welfare states—societies that tend to produce large sectors of informal care; and weaker demand from societies with well-developed formal social services and general acceptance, if not preference, for state provisions. In the following sections I discuss the extent to which these hypotheses make sense. I do not apply them to actual data, since my research has not yet gotten to that point, but this preliminary discussion should allow me to refine my hypotheses. Reflecting the robust literature on migration and care work that now exists, I draw insights examples from North America and Asia as well as Europe.

The Public in the Private

In societies that consider care a family responsibility, arrangements are likely to be home-based and services will be provided, whenever possible, by relatives, either unpaid or (under certain cash-for-care schemes) paid. When family members are not available, paid care workers—usually women—are recruited—and this, of course, is where migrants often come in. When such workers are hired singly, work intimately and individually with the family member(s) requiring care, and spend a great deal of time within the household (sometimes living in), their employment does not necessarily challenge familial ideals of care. Their conditions of employment allow families to view such employees as surrogate family members or, in the case of child care, “mother-substitutes” (Williams 2010; Bettio et al. 2006).⁴

In some societies, migration regimes are designed to naturalize such arrangements by encouraging immigration on the part of women who will be ethnically harmonious with native-born families. Such measures will, it is thought, facilitate the assimilation of migrant care workers as “one of the family” (though it is not clear that is migrants’ goal in the first place).⁵ Thus Spain welcomes women from Latin America (Bettio and Plantenga 2004), while Taiwan seeks women from other parts of Southeast Asia (but *not* China) (Lan 2006, chap. 1). Similarly, intra-EU migration policies are designed to lessen inter-ethnic conflict by encouraging migration from the new member states of Central and Eastern Europe to the old. In cases where there are undeniable linguistic and/or cultural differences between families and caregivers, employers may rationalize their choice by citing cultural enrichment for their children (Anderson 2010) or claims that certain ethnic groups have more respect for the elderly. But even among employers and employees who are racially, ethnically, and/or religiously similar, tensions arise that prevent migrant care workers from gaining full acceptance into their employers’ households. As conflicts

and class hierarchies emerge (often abetted by stereotypes on both sides), racialized or ethnicized interpersonal relationships come to embody global inequalities (Duffy 2005; Lan 2006, chap. 2).

Attempts to naturalize—or, perhaps more accurately, “familize”—the employment of care workers and bring it into conformity with prevailing care ideals are examples of the kind of adaptive strategies I noted above. In addition to the interpersonal issues just discussed, other features of such arrangements belie the idea that they are purely familial or private. For one thing, they may be underwritten, facilitated, and/or regularized by different types of state laws and policies, such as financial provisions that support the employment of care workers, workplace regulations, and/or migration regimes designed to facilitate the entry of foreign care workers into the country. The first set of policies includes cash-for-care payments to elders, as in the UK (Cangiano et al. 2009), and subsidies to working mothers allowing them to hire nannies, as in Spain (Bettio et al. 2004). The second set includes au pair schemes, as in Italy, Spain, and the United States; the Live-in Care Program in Canada (Bourgeault et al. 2009); and generous immigration quotas for women who are willing to take jobs as careworkers, as in Spain (Bettio and Plantenga 2004) and Taiwan (Lan 2006, chap.1). Also in this category are the liberal laws and regulations overseeing migration within the enlarged EU, which have sparked widespread migration from the new members in Eastern and Central Europe to the old member-countries in the West (Lister et al., 2007, 141-4, 171-2). The third set comprises wage-and-hour laws and restrictions that cover domestic work, often including au pairs, as in Denmark (Stenum 2008, section 6.)

When such incentives are absent, weak, or contradictory, state policies regarding migration, care and employment may be said to shape in-home care work in a perverse way, by creating a “gray market” of informal employer-employee relationships and working conditions

that either skirt the law or cry out for regulation. Most prominently, tight immigration restrictions coupled with high demand for workers encourage illegal immigration and the hiring of undocumented workers, who are the most vulnerable to abuses such as overwork and under- (or no) payment. Even in the case of legal migrants or native-born careworkers, Employers may seek to pay “under the table” to avoid taxes or social insurance fees.

Gray-market employment involves risks for both employers and employees, but those on each side have their reasons for participating: employers hope to lower their costs and/or extract more work from their employees, while employees who lack proper documentation may have no alternative. In addition, workers whose immigration status depends on staying with a particular employer may be fearful about challenging unfavorable practices lest they lose their jobs. The entire system may be driven by informal networks, extra- or illegal agents or recruiters, or commercial staffing services that act as a buffer between employer and employee—not always to the benefit of the latter. Shielded from legal regulations and outside scrutiny by its physical, structural and ideological features, in-home care work becomes a prime site for illegal or quasi-legal migrant labor employment—and for abuse, from both sides (Smith 2006-7).

The United States offers a compelling illustration of how the mismatch between a weak welfare state regime and a tight migration regime can facilitate the expansion of a gray market in care work. Throughout its history, responsibility for care has rested primarily on individuals and their families. The weakness of the U.S. welfare state is, however, less a product of a familial ideal of care (though there remains some of this, particularly with regard to children) than of long-term liberal and now neoliberal reliance on the market and the voluntary sector, rather than the state, for the organization of and much of the financial support for social provision of all sorts, including care services.⁶ From the beginning, middle- and upper-class Euro-Americans

looked to racial and ethnic minorities, including African Americans and successive waves of immigrants (mostly legal), to provide in-home care for children and perform domestic work, while relying more heavily on group facilities, largely voluntary and denominational, for elder care (Glenn 2010; Michel 1999; Achenbaum 1983).⁷ (Here is an example of the kind of split or mixed structure and culture mentioned above.)

In recent decades, however, as the result of increasing demand for care due to rising rates of female labor force participation and gains in life expectancy, on the one hand, and a declining supply of care workers due to expanding occupational choices for domestic minorities, on the other, Americans have come to rely increasingly on migrant care workers; by one estimate, some 20 per cent of the elder care labor force is currently made up of immigrants (Smith 2006-7). Immigration laws, however, are woefully out of synch with the demand for care workers. Quotas for unskilled adults, particularly women, who might fill such jobs remain too low to fill existing needs, with the result that each year tens of thousands of job-seekers, largely from Latin America, enter the country illegally to take up available positions (suggesting that the estimate of 20 per cent of all care workers may, in fact, be too low).

As a result, the weak American welfare state not only acts as a powerful magnet for in-home migrant workers, with all the potential for abuse that this type of employment entails (Smith 2006-7), but exacerbates the problem by compelling workers to migrate illegally. This is not to deny migrants' agency in the process, but I would argue that, on the whole, their motivations are benign and their availability and willingness to provide care a boon to hard-pressed family members with care responsibilities—particularly women. Though there is general consensus that the immigration system is “broken,” the country's political stalemate dims prospects for fixing it anytime soon (Martin 2010).

It is worth noting that in 2009, Italy, faced with a similar situation—high demand for migrants coupled with a dysfunctional migration system that encouraged illegal entry--decided to eliminate it by regularizing immigration for “non-EU citizens employed as home helps and carers.” As a result, nearly 300,000 workers who were already employed in Italy came forward and made themselves known to the government. (At the same time the government increased penalties for illegal immigration; OECD 2010, 98.)

The U.S. is but one example of the way in which weak welfare states, whether rationalized by a familial culture of care or by neoliberal ideology, help shape in-home arrangements, while upholding a culture of care based on familial responsibility. It also shows how a weak or informalized care regime, coupled with a tight migration regime, can encourage illegal migration. At the other extreme—in Spain, for example—a weak care regime coupled with an affirmative migration regime, will also stimulate migration, but of a legal variety (see Appendix).⁸ Italy’s recent “correction” now places it in the same category.

The Private in the Public

But do strong welfare states generate *less* demand for migrant care workers? To some extent, yes: the emphasis on group and collective facilities, a preference for professional workers, and the availability of high-quality, affordable services for children and elders not only minimize demand for private or in-home providers but also create a culture of care that discourages employing persons--of any national origin—in such positions (Lister et al. 2007, chap. 5; Williams 2010). Ironically, of course, robust regulation, good salaries and favorable working conditions make the public, socialized services in these societies attractive places to work, but low quotas for unskilled migrants in societies with strong welfare states have, at least until

recently, also kept migration to a minimum,⁹ with the result that female migrant labor pools in such societies tend to be quite small.

In strong welfare states—found in their purest form in the Nordic social democracies--the idea of hiring non-family members to provide care, no matter how highly paid, simply does not sit well with the native-born populace (Williams 2010.) The prevailing culture of egalitarianism entails an unwillingness to exploit others; antipathy to familial, privatized solutions; and a preference for public, collective, socialized solutions to personal needs. These values are the product of policy feedback, but they also reflect the long history of the kind of social democratic thinking that originally put those policies in place, and they continue to reinforce such policies in a kind of feedback loop.

Nevertheless, welfare state regimes and the cultures they produce do not remain stagnant. They must respond to political challenges, such as those that have been recently been mounted from the right in Sweden and Denmark, and they must also adapt to changing social and economic conditions--even conditions that they themselves produce (such as increased female labor force participation). In response to new conditions and new needs, service users may seek to modify existing social provisions or—if that does not occur quickly enough—look to the private sector. At the same time, commercial interests—abetted by center or right-wing parties—may seek to attract consumers for their services.

Denmark is a case in point. The country's au pair program (like that of other West European countries) was originally intended to facilitate short-stay cultural exchanges for young women from (Western) Europe and North America (Jakob Bang in Stenum 2008, 6). Over the past decade or so, the profile and scope of the program have changed (Stenum 2008). The number of au pair entry permits issued has increased by almost 700 per cent (from 318 in 1996 to

2207 in 2007), and the countries of origin have shifted to Eastern Europe and, overwhelmingly, the Philippines (au pairs from that country alone rose from 3 per cent of the total in 1996 to 68 per cent in 2007; Stenum 2008, 7, 15). To many, the program no longer appears to be one of cultural exchange but simply a scheme to bring in guest workers who will provide domestic service.

In Sweden, too, attitudes toward hiring in-home help are beginning to shift, again rationalized by the need to reduce stress in family life. In addition, Swedish employers (largely female) cite the decline in the quality of public child care due to cutbacks in government funding, as well as men's failure to take up their share of domestic burdens (Lister et al. 2007, 158). With no allotment for non-EU immigration by unskilled workers, the au pair system offers the only legal avenue into the country for would-be domestic employees, and the numbers of young women entering this way have been steadily increasing over the past few decades, with the majority coming from the Baltic countries. More recently, Sweden has begun to provide tax breaks to those who hire in-home help (primarily for housework). This measure has not only eroded the social democratic resistance to hiring "servants" but also served to increase the demand for domestic workers—a demand that is likely to be met by female migrants (Williams 2010). Similar incentives exist in Finland, which, despite its well-entrenched system of universal state-supported child care, has begun offering state support for in-home child care.

Finally, there is a trend, albeit somewhat halting, toward the commercialization of social services. In Sweden, this began in the mid-1980s with the debate over whether Pyslingen, a for-profit child care company named for a popular Swedish children's-book character, should be allowed to operate. Opposed by the Social Democrats but supported by the Moderates and the Swedish Association of Employers (SAF), this company and others like it finally gained

permission to open child care centers, though they are required to adhere to the same regulations as state-run facilities. By 1997, these firms were employing almost 10 per cent of all child care workers in Sweden (Daune-Richards and Mahon 2001; Earles 2004). Similarly, in Denmark, after some resistance, the commercialization of in-home services for the elderly has taken hold (Jarden and Jarden 2002). Because they want to keep labor costs low, commercial services are probably more likely to hire migrants than native-born workers when possible.¹⁰

What is causing the social democratic consensus on private service to erode? Despite the power of “policy feedback,” conditions change, and measures that served effectively during one period may prove unsuitable in another. Too, expectations for quality and convenience are rising. Thus, for example, parents in an adult-worker family may find that the hours for the child care services on offer in their community do not fit their complicated work schedules or long commutes; or a full-time working daughter may feel that she cannot adequately supervise the group care available to her aging parent who lives at a considerable distance. In both of these instances, hiring an in-home caregiver may seem like the best solution. But practicalities are only one issue; cultures, or ideals, of care also enter into the mix, and here, as we have seen, public discourses are also changing, largely as a result of growing influence of conservative or moderate parties in once-impenetrable bastions of social democracy.

Let’s look again at Denmark. Conservative Danish officials have publicly condoned hiring au pairs for domestic service in order to relieve the stress of modern family life. In 2007, then-Family Minister Carina Christensen, a member of the conservative Danish People’s Party, even intimated that this was necessary to encourage women to keep having babies. As researcher Helle Stenum suggests, “When a family minister makes the statement that ‘the perfect mother’ may be reinterpreted by the hiring of an au pair, then it is a clear signal of new standards

evolving” (2008, 8). To be sure, Christensen’s views may have been one-sided; nevertheless, they do seem to indicate a breach in Denmark’s solidly social democratic ethos.

At the same time, one may trace the growing supply of Filipina au pairs back to the policies of their government, which has, through a series of measures, powerfully stimulated migration for many decades. As Stenum and many others have pointed out (e.g. Parreñas 2003), the Philippines stands out as the world’s leading exporter of migrant labor in general. With a marked recent shift in emigration from men to women, Filipinas are now working in some 192 foreign countries and remitting billions of dollars (or the equivalent) annually. The high rate of female labor migration is motivated by both personal needs and ambitions as well as government incentives, including health care coverage and old-age pensions. Although Filipino law prohibits migration expressly to take up positions as au pairs, many Filipinas manage to find ways to take such jobs in Denmark, attracted to them precisely because of how they are defined and the fact that they presumably entail fewer hours of work (though they are also less remunerative). The Filipino law is meant to protect migrant workers, but, according to Stenum (2008, 16), this is no longer necessary since legislation recently passed by the Danish Parliament addresses these concerns.

It is worth considering one additional reason for the growing acceptance of hiring in-home care workers in the Nordic countries: the increased availability of foreign-born persons who might be employed in such jobs. Whereas immigration restrictions have been or become lax in most of the weaker welfare states elsewhere in Western Europe, particularly in the south, the Nordic countries have tended to keep theirs tight. For example, as is well-known, after World War II, when West Germany was recruiting “gast-arbeiter” from Turkey, Sweden made the decision to mobilize its own female labor force rather than bring in “foreigners.” To the extent

that labor migrants were welcomed in the 1950s and 1960s, they came primarily from other Nordic countries. Such policies served to maintain ethnic homogeneity in the Nordic countries and also help explain the strength of their welfare states.

It is only recently that this has begun to change, largely as a result of another of the Nordics' firmly-held positions: the need to provide asylum for refugees. Since the 1970s, refugees from the Middle East, Latin America, and more recently the former Yugoslavia have flowed into the Nordic countries, altering the once relatively homogeneous profile of their populations. In Sweden, foreign-born persons now make up 13 per cent of the population, while in Iceland the proportion is 9 per cent, Denmark, 8 per cent, and Finland, 4 per cent. While this shift has impelled the Nordics to keep a tight lid on other types of immigration, it has left these countries with substantial pools of low-educated and low-skilled persons. High rates of unemployment and welfare dependency among refugees have led to long, often bitter debates about the added burden to their already generous social budgets (Hedetoft 2006). Thus, one might speculate that the desire to see more of this population employed could override native-born Nordics' long-held adherence to a strict social democratic ethos. Further research will be needed to ascertain if this is, in fact, the case.

Conclusion

Statistics from the early 2000s suggest that my hypotheses, however rough, were generally holding: weaker welfare states tend to hire more female migrants as care workers, stronger ones, fewer—and mixed regimes somewhere in the middle (see Appendix). According to the OECD, in 2001 nearly 15 per cent of the foreign-born in Spain were working in households, while in the

UK, the figure was 1.3 per cent, and in Sweden it was “statistically insignificant” (Williams 2010, citing OECD 2005).

More recent data, however, indicate that the differences between strong and weak states may be shrinking. The Swedish Integration Board, for example, reports that from 2000 to 2004, the proportion of foreign-born women working in health care and “private service” in Sweden was almost always a few points higher than that for native-born women. Figures ranged around 11 per cent vs. 8 per cent in for women working in private service, and 30.2 to 33.9 per cent vs. 27.8 to 33.3 per cent for those in health care (Lundberg 2007). The rise in the number of foreign-born, non-EU au pairs working in Denmark (discussed above) suggests a similar trend there. Trends in the UK—a mixed regime—are also changing; currently 17 per cent of all care workers for the elderly in the UK consist of ethnic minorities, largely female (Cangiano et al. 2009). In the U.S., foreign-born workers make up about 14 per cent of the total labor force but 20.9 per cent of direct care workers. Of these, 21 per cent are estimated to be unauthorized (undocumented) workers (Martin et al., 2009, 23-4).

These trends seem to be persisting, despite the economic downturn. The most recent figures from the OECD (2010) show that while the recession has sharply affected migrants in many occupational sectors in both Europe and the U.S., it has had less impact on those in care work occupations. Unfortunately, the categories used for the two labor markets are not identical, so it is difficult to make precise comparisons, but the statistics are nonetheless revealing. In Europe from 2008-2009, the proportion of foreign-born workers in “residential care activities” (presumably nursing homes and the like) increased by 23.8 per cent, while that for native-born workers rose by only 6.2 per cent. (OECD 2010, 112). In the U.S., the number of foreign-born workers in “social assistance” jobs increased by 18.2 per cent (no number was reported for

native-born workers in this category), but in health care services (except hospitals), the figure increased by only 2.7 per cent, while it rose 5.5 per cent for native-born workers (OECD 2010, 113). This last discrepancy may be explained by increased efforts on the part of the US government to “crack down” on undocumented immigrants in certain industries.

The preceding discussion suggests that the factors determining the demand for female care workers are “nested.” That is, the growth of aging populations and increased rates of adult female labor force participation (making traditional caregivers unavailable) may be seen as root causes, but how the resulting need is met depends on a number of other factors—social, economic, political, and cultural. Following Williams’ use of multiple regimes as explanatory factors, my analysis has shed light on why certain societies attract more illegal immigrants than others, and also points to ways in which care regimes and cultures of care may change over time. While differences between strong, weak, and mixed welfare state regimes persist, they are not as marked as they were even a decade ago, partly because of the eroding commitment to a social democratic ethos discussed above. Indeed, some observers (Williams 2010, for instance) see greater convergence in the offing—convergence that will tend more toward employment of in-home care givers than toward collective public provisions. This tendency will find reinforcement in the demographic and female employment trends in the global North, which continue to produce a demand for foreign workers, and in the economic conditions in the global South and Eastern Europe, which continue to stimulate labor migration.

As long as these conditions (however undesirable) persist, the global care drain will also continue, and policymakers must find ways to come to terms with them, if only on a temporary or meliorative basis. While the issue is a global one, my findings point to at least two policy areas where the receiving countries should take action. First, conditions for in-home workers

should be improved; wages, hours, benefits, food and accommodations must be consistently regulated to prevent abuse and ensure workers' health and old-age security, and care workers should be offered training, to improve the quality of in-home care. Second, it is clear that none of this can be achieved without full acknowledgement of the ongoing need for care—a need that is not being met domestically--and rational, realistic reconciliation of demands for foreign workers, on the one hand, with migration laws and regulations on the other. As the example of Italy shows, this is the only way to reduce levels of undocumented or illegal immigration and ensure a more regular and predictable flow of the kinds of workers that are needed. At the same time, global equity requires attention to conditions at the other end of the “global care chain”-- the “care deficits” resulting from widespread female emigration—and the kinds of policies needed to address them. Such issues are, unfortunately, beyond the scope of this paper, but must be included in future research if it is to be comprehensive.

Appendix

Care Regimes and Migration Regimes in Selected OECD Countries

Country	Provisions for Child Care	Provisions for Elder Care	Other Domestic Services	Migration Policies
Denmark	Universal child care	Universal public support through in-home services and group facilities		No quotas for care workers Au pair program in place Refugees encouraged
Finland	Universal child care Cash provision / tax credit	Public support for in-home services to encourage independent living		
France	Universal child care for ages 3-5 Cash provision / tax credit for parents with younger children	Cash-for-care		
Italy	Public child care in the north but not the south	Cash-for-care scheme		Quota allocations for domestic/care workers Au pair programs
Netherlands	Cost for both formal and informal care shared between parents and state; state share decreased in 2010	Cash-for-care scheme		
Norway	Subsidies for both child care and stay-at-home parents	Universal public support through in-home services and group facilities		
Spain	Subsidies to working mothers hiring nannies	Some public in-home services, but most care provided by family members		Quota allocations for domestic/care workers Au pair programs
Sweden	Universal child care starting at age 1 Paid parental leave for parents with infants	Universal public support through in-home service and group facilities	Tax concessions to private employers hiring domestic help	No quotas for domestic/care workers Generous refugee program
UK	Cash provision/tax credit Formal care varies by country	Cash-for-care scheme		Working holiday permits Au pair programs
US	Market-based in-home and group care except for low-income families	Market-based in-home and group care except for the indigent		Limited au pair programs No quotas for care workers

Legend: Prevalent type of care services

- Informal care schemes
- Formal, state-sponsored care
- Market-based system

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¹ In my proposal to this conference, I offered two more hypotheses: that migrants who do not speak the native language of a particular country are more likely to find work in elder and disability care than in child care, and that there is greater demand for female than male migrants, and that the gender of these workers and their isolation within individual households rather than within formal employment affects the quality of migrants' working conditions. Since other papers in this stream address these issues in detail, I largely leave them aside in this paper. For an excellent discussion of the detriments of private-sector employment across a range of cases, see Kröger and Zechner (2009).

² These may be either state-run or contracted out to commercial or voluntary providers.

³ A classic example is the rationale for placing children in child care so women could work in defense industries during World War II, which appeared in the societies of nearly all the belligerents. See Michel 1999, chap. 4. In the US this was explained as a measure that was necessary for victory in the war, but, the public was assured, it was “for the duration only.”

⁴ When such workers are hired through staffing services—that is, when they become commodified, this becomes more problematic.

⁵ Being considered “one of the family” has both advantages and disadvantages as has been richly documented in the abundant literature on this subject. See, for example, Lan 2006; Constable 1997; Parreñas 2008, etc.

⁶ That is, the bulk of health care and retirement provision—including Social Security—are paid for by employers and employees; there are subsidies for the very poor for health care and child care, and for the elderly for certain types of health care. Public support for home health care has, however, recently declined; see Jane D. Albritton, “Medicare funding for home health care declines,” *Northern Colorado Business Report* 14 May 2004;: <http://www.allbusiness.com/business-finance/equity-funding/1132991-1.html>.

⁷ Sociologist Mignon Duffy (2005) makes a distinction between “reproductive” and “nurturant” care work, and points out that in the U.S., racial and ethnic minorities tend to be concentrated in the former. The two categories are defined as follows: “Reproductive: Work that maintains daily life (physical or mental health, food preparation and service, cleaning, personal care) or that reproduces the next generation (care of children and youth). Nurturant: Work that entails face-to-face service to clients, not managers or other employees. The face-to-face service provision should constitute a major part of the worker’s time, and the face-to-face service provision must develop the human capabilities of the recipient—these are defined to include physical and mental health, physical skills, cognitive skills, and emotional skills.”

⁸ Williams (in Lister et al. 2007 suggests that with regard to private child care, “it is probably only Spain that fully fits the notion of the ‘global care chain’ where the majority of women migrants have left their own children behind to care for others’ children” (161).

⁹ Except for health care professionals such as physicians and nurses, who are in great demand. The same is true for many other EU countries, including those with mixed or weak welfare states: Belgium, France, Germany, Ireland, the Netherlands, Spain, and the United Kingdom (OECD 2007.)

¹⁰ In “weak” welfare states such as Spain, social services have apparently become an attractive target for commercial investment. See, for example, the following advertisement: <http://www.homeinstead.com/International/franchise-opportunity/Pages/Spain-Senior-Home-Care.aspx>

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