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BARRIERS TOWARDS EU CITIZENSHIP

CITIZENSHIP IN THE CONTEXT OF MIGRANT CARE WORK

Regimes, Rights & Recognition

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EXECUTIVE SUMMARY

This report derives from the work of partners involved in Work Package 9 of the FP7 programme bEUcitizen: Utrecht University (NL); the University of Zagreb (HR); Aalborg University (DK); Central European University Budapest (HU); the Hebrew University of Jerusalem (IS); The University of Turin (IT) and the University of Oviedo (ES). This report studies the way the complex dynamics of individual member states' care, migration and employment policies impact on the citizenship status of migrant care workers. It also explores the extent to which migrant care workers from EU versus non-EU countries (i.e. third country nationals, TCNs) can exercise citizenship rights across the EU15 (Denmark, Italy, the Netherlands, Spain), new members (Croatia and Hungary) and non-EU states (Israel).

Relation between the 'right to receive care' and migrant care work

The categorisation of 'migrant care worker models' that we introduce – the 'state-supported professional MCW model' (DK, NL), the 'state-supported domestic MCW model', (ES, IT), and the 'legalised-informality MCW model' (HR, HU) – demonstrates under which conditions distinct patterns of migrant care work prevail. In countries where citizens have *the right to receive professional LTC services*, a well-developed formal LTC system exists in which care is provided by trained professional workers. In migration policies access is restricted for unqualified workers from third-countries and highly-skilled workers have privileged access (DK, NL). Migrant care work prevails in those countries where the family logic of care prevails and where citizens have *the right to receive non-professional LTC* (ES, IT). LTC systems in which care is provided in the informal sphere by non-professional workers may be characterised by a large underground economy, which may represent a favourable condition for the informal employment of MCWs as live-in workers. When the state supports care provision within the private household through the entitlement to cash-benefits schemes, hiring non-professional migrant care givers is facilitated (ES, IT). The absence of a well-developed professional LTC system seems to imply that less restrictions are imposed on the educational requirements for TCN migrant care workers, which also facilitates entry for low-skilled migrant care workers. In countries where the family logic is dominant, but where the state does not recognise citizens' right to receive (non-professional) LTC by offering cash benefits, care receivers seem to be less likely to hire a migrant care worker (HR, HU).

Access to citizenship rights depends on labour market position and residence status

The type of work and/or residence permit a migrant care worker holds is key to understanding their access to social security benefits. Migrant care workers – except those entering the host country on a 'highly-skilled worker' status – are in a vulnerable position due to the (often) temporary character and/or irregular nature of their employment status, which makes it hard to gain financial independence, and subsequently a permanent residence status. Migrant care workers' attainment of citizenship rights is therefore circumscribed by their position in the labour market. For migrant care workers, the way to receive social citizenship rights is narrowed down to being financially independent, making regular paid employment in the key to social citizenship.

1. Introduction

1.1 Boundaries of European citizenship: conditioned rights

> *"Any person who holds the nationality of an EU country is automatically also an EU citizen. EU citizenship is additional to and does not replace national citizenship. It is for each EU country to lay down the conditions for the acquisition and loss of nationality of that country" (European Commission, n.d.).*

The legal concept of citizenship of the EU was formally introduced in 1993 by the Treaty of Maastricht. EU citizenship is restricted to a small range of rights and is mainly related – although not exclusively – to the mobility of EU citizens; the right of free movement and the right to reside in an EU member state other than the one of which they are nationals, e.g. as workers or students. However, EU citizenship rights are not fully comparable with national conceptions of citizenship. Contrary to the limited bundle of legal and economic EU citizenship rights, national citizenship includes a large number of civil and social rights. Additionally, EU citizenship is conditioned by the possession of national citizenship. This implies that member states have absolute control in deciding who becomes a citizen within their territory, and subsequently, who becomes an EU citizen (Ferrin & Cheneval, 2014). The interaction of EU citizenship with national sovereignty and citizenship has implications for the citizenship rights that can be exercised by EU citizens residing in another member state. Thereby the boundaries of citizenship and its relationship to member states' labour markets and welfare state arrangements are reconstructed. The emergence of EU citizenship has also demarcated the legal construction of EU versus non-EU citizens; i.e. the establishment of 'Third Country Nationals' (TCNs). As citizens of EU member states became insiders of the EU, citizens of non-EU states were turned into EU outsiders (Anderson, Shutes & Walker, 2014). Although citizenship epitomises rights and inclusion, it also works as a mechanism of exclusion and deprivation (Anderson, 2010: 63). Unlike non-EU citizens (i.e. TCNs), EU citizens benefit from intra-EU mobility rights and have privileged access to the labour market[1]. Moreover, their rights to family life are safeguarded to the same degree as those of national citizens (Erel, 2012).

Due to variation in individual member states' immigration policies, there has been a "continuing diversification of legal statuses and associated rights" (Anderson, Shutes & Walker, 2014: 8), not only between EU and non-EU citizens, but also *among* TCNs, depending on their source of entry (e.g. as a worker, family member, student or asylum seeking). In Europe, TCN migrants' rights of mobility,

[1] However, citizens of new EU members states have had restricted access to the labour markets of most EU 25 countries until 2011. The UK, Sweden, Ireland, Italy and Spain have opened their formal labour markets to migrant from new EU member states from eastern Europe (Erel, 2012).

residence, and family unification are contingent on the circumstances of migration and are hence stratified (Morris, 2002). Due to constraints in migration and labour policies, TCNs have more restricted access to social rights provided through the welfare state (Erel, 2012). For these reasons, the EU borders have been described as 'polysemic' (Balibar, 2002), indicating that they have distinctive impact on those who cross the border (Anderson, 2010). Therefore, not all TCNs are to the same extent excluded from citizenship rights. For example, knowledge workers may be acknowledged by member states in their capacity to contribute socially and economically and may be given privileged access and are, on the basis of their social and economic contribution, granted social protection by the welfare state. This current report explores the implications of the 'polysemic EU borders' on the extent to which migrants from EU versus non-EU countries, working in the long-term care (LTC) sector, can exercise citizenship rights across European countries.

1.2 Migrant care work in Europe

> *"(M)igrant care workers remain at the boundaries of citizenship despite their contribution to the social reproduction of Europe and its citizens" (Erel, 2012: 5).*

Demographic aging combined with the movement of middle-aged women into wage employment, changing perceptions of care responsibilities, and the disadvantaged and female-centred nature of long-term care as a sector of employment has led to a growing reliance on female migrant workers in the provision of LTC in most European countries. With few exceptions, over the last decade the migrant share of the EU workforce has increased far more in caring occupations than in the rest of the labour market (Cangiano, 2014). However, although the phenomenon of migrant[2] care workers is experienced by most European countries, there is a lack of knowledge on its extent and its varying patterns across member states (Da Roit & Weicht, 2013). Moreover, the number of migrant workers employed in formal and informal care varies widely across countries (OECD, 2011). In addition, since legal status, political and social rights, employment conditions and legal and institutional protection differ widely across various employment situations it can be asked whether migrant care workers constitute a sociological group that faces similar, comparable structural possibilities and constraints in exercising citizenship rights. To what extent do rights differ across long-term care systems, employment situations, and migration trajectories? Is migrant care work recognised as a route to citizenship? To identity the different sources of constitutions of rights it needs to be noted that migrant care workers

[2] Williams (2012) points to the methodological challenge of collecting cross-national data on migrant care work. "Definitions of who is and is not a migrant or a naturalised minority ethnic group member are not cross-nationally consistent" (2012: 365). This can be an important distinction when the long-term care workforce is comprised of both first- as well as second and third generation minority ethnic groups. In the present report, migrants refer to foreign-born individuals who may be nationals of the European Union (EU) or third country nationals (TCN) and who work in a foreign country. This means that, with a few exceptions, so-called second- or third generation are omitted from the discussion here. However, in the various national sources that are used in this report, migrants can be defined by either their country of birth (foreign born), by foreign citizenship, or by their movement into a new country. In the analysis, we try to be as specific as possible about the group to which the data refer.

can gain citizenship rights from different aspects of their position, role and identity (e.g. as family-member, as worker or as citizen of another EU country). It is important to realise that the LTC workforce is highly gendered across all countries; women are overrepresented in both formal and informal LTC sectors (Cangiano, 2014). So, when the position and rights of migrant care workers are discussed, this actually concerns the position and rights of *female* migrants care workers.

This report (Deliverable 9.6) builds on approaches that emphasise that the extent and patterns of migrant care work across Europe can only be understood by analysing the intersection of care, migration and employment policies and arrangements (Da Roit & Weicht, 2013; Lyon & Glucksmann, 2008; van Hooren, 2012; Williams, 2012). It can therefore be assumed that institutional variety affects patterns of migrant care work. The objective of Work Package 9 (WP9) of the FP7 programme bEUcitzen is to study the relationship between the effects of discrepancies between respective civil, political, social, and economic citizenship rights and obligations of European and non-European citizens (as family members) moving across borders. Deliverable 9.6 deals with the way the complex dynamics of individual member states' care, migration and employment policies impact on the citizenship status of migrant care workers. The aim of Deliverable 9.6 is threefold. First, to understand how patterns of migrant work in long-term care[3] in six[4] EU member states and Israel are contingent on national care, employment and migration policies. Specifically, to understand the relationship between national citizens' right to receive professional care and a country's reliance on migrant care work. Second, to understand the implications of the reliance on, and prevalence of, migrant care work for the citizenship rights[5] that can be exercised by migrant workers in LTC. Third, by studying the phenomenon of migrant care work we gain insight in the extent to which the right to receive professional long-term care is considered an integral part of citizenship and, implicitly, the extent to which migrant care work is recognised as a socially and economically valuable activity.

Seven partners participated in this work package, most members come from a sociology/social policy background. Five have expertise in EU15 states – Utrecht University (The Netherlands), Aalborg University (Denmark), University of Turin (Italy), and the University of Oviedo (Spain). Two partners have knowledge of central European states that have entered the EU more recently; the Central European University of Budapest (Hungary) and the University of Zagreb (Croatia). One partner from a

[3] Long-term care is defined "as care for people needing assistance with various activities of daily living (ADL) over a prolonged period of time. A broad definition includes not only personal care such as bathing, dressing, and eating, but also additional tasks in which older and disabled people might not be self-sufficient (e.g., shopping, preparing meals, housekeeping)" (Cangiano, 2014: 150).

[4] Croatia, Denmark, Hungary, Italy, Spain and the Netherlands.

[5] This report focuses on the right for migrant care workers to have access to *social security benefits*, because social security systems constitute a powerful tool to reduce inequality and poverty and to promote social inclusion.

non-EU state is involved; the Hebrew University of Jerusalem (Israel). Rather than being selected purposively, all partners involved expressed an interest in the work package and its particular focus. The study is limited with respect to the absence of partners from core EU states such as France and Germany, nor from the 2004 accession states. Yet, the purpose of this report is not to produce generalizable findings. Instead, this report attempts to understand how the reliance on migrant care work and the citizenship rights migrant care workers can derive from their position is conditioned by the (unique) combination of care, employment and migration regimes across states.

In order to prepare the D9.6. report, each of the participating partners in WP9 contributed a country report with data on the respective countries on the care regime, the employment regime, and the migration regime. The so-called 'sending countries' were asked to provide information on citizenship rights migrant care workers (might) still hold from their countries of origin. There was a specific section of questions focusing on the migration trajectories, include differentiations related to the following cases: EU workers, European but non-EU workers, and non-European workers. The partners' reports also explored the nations' reliance on migrant care work. Drawing on the information provided by partners, the WP9 coordinator, Utrecht University (The Netherlands), then drew out the lines of comparison from each country to explore how the intersection of care, employment, and migration regimes can explain the variances in patterns of migrant care work as well as the citizenship rights that migrant care workers can derive from their position across nations.

The report is structured as follow. The remaining part of this first section deals with an academic literature review on (the intersection of) care, employment and migration regimes. Section 2 provides an overview of the reliance on migrant care work across European countries, i.e. the number of migrant care workers that are employed in the formal as well as informal long-term care sector. An elaboration on the care regime is provided in Section 3, including a discussion on national citizens' right to receive affordable and good quality care. Section 4 and 6 elaborate on, respectively, the employment and migration regimes across the selected countries, while section 5 offers an analysis of the level of social protection ensured to migrant care workers. It is the *combination* of these three regimes that constitute the citizenship status and accompanying rights of migrant care workers. Subsequently, the accessibility of citizenship for EU and non-EU migrant care workers will be discussed in the Discussion and Conclusions, *after* the interplay of care, employment and migration regimes has been assessed.

1.3 Intersections shaping citizenship rights

Care, employment and migration policies and regimes do not function independently from each other but are interlinked in creating particular conditions for migrant care workers and national care recipients to exercise citizenship rights. The intersection of care, migration and employment regimes is described and conceptualised by several authors as different variations and configurations (van

Hooren, 2012; Williams, 2012; Da Roit & Weicht, 2013). Williams and Gavanas (2008), focusing on employment of home-based childcare in three national contexts – UK, Spain and Sweden – have highlighted how the interconnection of care policies and migration regimes affect the role of migrant labour in (paid) care work. Simonazzi (2009), analysing the interaction between care regime and (national) employment models, connects the particular national organisation and financing of long-term care for older people with the overall working conditions and qualification levels to be found in the employment of care workers. Shutes and Chiatti (2012), analysing the intersection of employment and care regimes, point out that in the UK institutionalised care services are not necessarily linked with more stable or better employment conditions for migrant care workers. Other studies show that the recent increase in migrant care arrangements in private households has primarily emerged in countries with a greater reliance on cash benefits instead of in-kind services, like in Germany (Neuhaus et al., 2009; Da Roit & Weicht, 2013), Spain (Leòn, 2010; Da Roit & Weicht, 2013), Italy (Lamura et al., 2010; Da Roit & Weicht, 2013) and Austria (Österle & Bauer, 2012; Da Roit & Weicht, 2013).

However, there appears to be a gap in academic literature with regard to the link between the intersection of care, employment and migration regimes, migrant care work and the citizenship rights migrant care workers are entitled to. Williams (2012) has formulated some operationalising indicators for regulations and policies which should allow for an identification of the relevant aspects of the policy intersections. Migrant care workers gain rights from different aspects of their social identity. The social rights that can be exercised by migrant care workers, depend on the entry and residence rights from their position as 'migrant' (e.g. do they enter the country on a work permit, on a residence permit or as a family member) and it depends on their labour market position as a 'worker' in the member states' LTC system (e.g. in residential care or in a private household). The next paragraphs explain how access to citizenship rights is contingent on the combined circumstances of care provision, employment conditions and migration regulation.

1.3.1 Care regime

> *"(D)espite the centrality of care for the reproduction of societies, states, and nations, it has only been precariously recognised as a citizenship practice. (…) Yet, their migration or citizenship status often precludes them [migrant care workers, RO] from claiming social citizenship rights and receiving care themselves in Europe" (Erel, 2-12: 4).*

In T.H. Marshall's influential conceptualization of citizenship, his third 'right of citizens' – social citizenship (in addition to civil and political rights) – embraces various human rights, including the right to health, housing, education, employment, and income (Marshall, 1950). Yet, the right to care was excluded. "In Marshall's day, care was viewed as part of the communitarian duty to care and was supposed to be provided by family and social networks" (Knijn & Kremer, 1997: 331). They furthermore

argue that this domestification of care forms the basis for the exclusion of the right to care as a citizenship right.

> *"The right to receive care implies accessible and qualitatively good institutional care to meet the demands of different groups of citizens who are in need. (…). The right to receive professional care is only enforceable when the services are good and affordable, so all citizens can and want to use their rights*" (Knijn & Kremer, 1997: 333).

Hence, the way the LTC system is organised defines the conditions under which care is provided – and by *whom* it is provided – and this is decisive for its quality (Knijn & Kremer, 1997). What about the educational level, employment conditions and career opportunities of (migrant) care workers? Do care receivers get adequate care, i.e. is long-term care accessible, affordable and of sufficient quality? As Bettio and Prechal phrase it: "(I)f provision is substandard, the right to care becomes an empty concept" (1993: 43).

Citizens' right to receive (professional) care, and the rights a migrant care worker can derive from its position in the long-term care system depends on the "ways in which the financing and provision of care are organised" (Simonazzi, 2009: 216), also in relation to the diversity of the care market composition between public and non-public actors: a country's care regime (Williams, 2012). Pfau-Effinger and Geissler (2005) have conceptualized the so-called 'care arrangement', an explanatory framework for the structuring of care work in a society. In this report the 'care regime approach' will be connected to the 'logics of care' framework, developed by Knijn and Verhagen (2007). The 'logics of care' framework provides a useful tool for analysing the social institutions involved in long-term care systems and helps to define the logic of care that is dominant in a country. Four logics of care have been distinguished: those of the state, the market, the family and the professions (Table 1.1).

Table 1.1 Logics of care

	Ideology	Institute	Caregiver	Care Recipient
Professional logic	Specialized knowledge and skills/ discretionary power	The specialised profession	Expert/specialist/ professional	Client/ patient
Market logic	Individual freedom	The commercial market	Entrepreneur	Consumer/ customer
State logic	Bureaucratic equality/ control and rules	The legislative state	Government/ ministry of health/ public servant	Citizen / taxpayer
Family logic	Family bonding/ group solidarity	The reciprocal family/community	Informal caregiver/ layperson	Care dependent: relative, friend or neighbour

Source: Knijn and Verhagen (2007: 461)

According to Kremer (2007), the right to receive professional care can only be enforced when citizens actually *will* and *can* exercise their right to receive good and affordable care services. She argues that such a right can only be demanded from the state, and not from the family or market. The care logic of the state is based on the idea that means need to be divided among (frail) elderly without arbitrariness but should instead be based on objective and controllable criteria. This implies that LTC is considered a public good that should be distributed based on impersonal grounds. In the care logic of the market long-term care is considered a commodity that is to be exchanged on a market by private and commercial actors. Competition between providers of care and availability of 'product' information are essential for a market to operate effectively and efficiently. Unlike the state logic, a long-term care system based on the market logic of care does not distribute services based on needs and interests of clients/patients, but on the consumer's market value; the market logics aims to maximise profits of long-term care providers. Like the market, the family is based on private relationships. However, the care logic of the family is not based on commercial relationships.

> Instead, familial relationships are based on "*kinship, reciprocity, bonding, and normative claim —hence family relationships are inclusive as well as exclusive. The definition of family boundaries is decisive for whoever is acknowledged or left out as a member of the kinship group, and this has consequences for people who are legitimized to receive and give support.*" (Knijn & Verhagen, 2007: 462-63).

In these private relationships care provision is characterised by solidarity and commitment founded on reciprocity and moral bonding. The professional logic of care is based on the professional claim of

training, expertise, knowledge, skills and experience, guaranteeing good quality care that is distributed based on clients' needs. Professionals have high levels of discretionary power in deciding how tasks should be fulfilled. They work according to professional guidelines, standards and follow a code of ethics, allowing them to claim occupational distinctiveness and maintain the privilege of work autonomy (MacDonald, 1995; Freidson, 2001; Knijn & Verhagen, 2007).

The logic of care that is dominant in a LTC system *defines* the care regime. It identifies the ideological forces behind the *criteria* and *instruments* used to distribute care. The logic of care approach also classifies the main *provider* of LTC. And, it helps to understand the *position of caregivers* and *care recipients*. The logic of care in a country's LTC system, shapes the right to receive care. A LTC system characterised by public care provision through the state distributes care based on "a justified distribution of provisions to those categories of (elderly) citizens who are accepted as having legitimate claims" (Knijn & Verhagen, 2007: 467). Although receiving care is in such a system defined as a citizenship right, allocated based on objective and impersonal criteria, it does not guarantee that care provision is based on the particularities of client's needs. Although family care may be based on "warmth, (…) it is parochial and arbitrary at the same time" (Knijn & Verhagen, 2007: 468). This implies that the right to receive care is disposed to subjectivity. This also goes for the quality of care provided by family members or laypersons, because the formal standards or criteria for the type of support that is provided, and for the educational degree of the care provider, are absent. Moreover, the working conditions for care workers in the family care logic are not indiscriminate; good working conditions are defined within the boundaries of the familial relationship, leaving ample room for arbitrariness. In a system dominated by the market logic of care, care is not considered a citizenship right: only those who can afford it have access to good quality care. In such an environment, the position of care workers is subject to the whims of the market. Care regimes in which long-term care is recognised as professional wage labour that cannot be provided on the basis of, for example, the familial logic of care, will guarantee its citizens good quality of care provided by trained, skilled and experienced professionals (Knijn, 2000).

The employment of migrants in the care sector depends on the policy arrangements that are in place in a country (Escriva & Skinner, 2008; Gerling, 2003; Hillmann, 2005; Lutz, 2008; Scrinzi, 2008; Williams & Gavanas, 2008). Da Roit and Weicht (2013) identify the availability of public care services as one of the main determents of the existence of substantial numbers of migrant care workers in a country. Van Hooren (2012) argues that differences in the importance of migrant workers in care can be explained primarily by differences in *care regimes*. For example, in Southern European countries, the increasing number of female migrant care workers has become a significant response to, among other things, the inadequacy of formal care provision (Sciortino, 2004; Lamura et al., 2009; Da Roit & Naldini, 2010). So, the demand for migrant care workers is highly dependent on the institutional structure of the care

sector, with public investments in the LTC sector making paid care jobs more attractive for native care workers and reducing the demand for migrant care workers (van Hooren, 2012). Because of the increasing reliance on private provision of LTC and a trend towards commodification of care, exemplified through for example cash-for-care schemes (Simonazzi, 2009; Williams 2011), the expansion of marketised care provision at home is encouraged. "Migrants, often with precarious access to residence permits and labour markets, make up a major source of this care labour" (Erel, 2012: 2). Yet, the reliance on migrant care work, and the citizenship rights migrant care workers derive from their position, are not merely defined by the care regime. Instead, the number of migrant workers in LTC in a country and the citizenship rights of these migrant care workers are shaped by the interplay between the care regime, employment regime and migration regime (van Hooren, 2012; Da Roit & Weicht, 2013). Therefore, the following paragraphs discuss the importance of identifying a country's employment regime as well as its migration regime.

1.3.2 Employment regime

The position of migrant care workers within the labour market is partly defined by the dominant logic of care within a country's LTC system. For example, if LTC work is recognised as *professional work* that cannot be just given intuitively on the basis of personal commitment, formal care provision will prevail over informal care provision (by family members or domestic migrant care workers). Thus, the reliance on migrant care work is shaped by the demand for and recognition of particular skills required to perform long-term care work (Anderson & Ruhs, 2010); is cleaning the house of frail older people recognised as wage labour that has to be given by experts or is it viewed as an ordinary housekeeping activity? The stratification within the LTC sector, and thus the socio-economic dimension of the professional status is partly shaped by the acceptance of diplomas and qualifications, training opportunities, the tasks related to one's work, the financial remuneration and the right to have access to social security based on one's position.

Broadly speaking, across Europe the LTC labour market is generally divided by home helps, care assistants, (community) nurses and management personnel (including for example head of wards). Home helps provide (formal or informal) domestic help at clients' homes (i.e. perform household tasks such as ironing and cleaning). Care assistants perform caring services, including personal care (bathing/dressing) and social activities. (Community) nurses deal with rehabilitative, supportive, promotive or preventive and technical nursing care. The extent to which educational requirements for the distinct jobs are standardised, and so the degree to which a certain occupation is recognised as a profession, defines the formal/informal character of a country's long-term care sector. For example, strict educational requirements might explain a low number of migrant care workers (Visser-Jansen & Knipscheer, 2004). Furthermore, labour market divisions may channel migrant care workers into specific jobs. Lutz and Palenga-Möllenbeck (2012) have argued that the prevalence of domestic workers

in long-term care is shaped by the size of the underground economy in a country and by the availability of (highly) skilled (professional) workers. In most countries LTC is characterized by low pay, poor working conditions, and limited career opportunities (Cangiano, 2014). Because the unfavourable employment conditions in the care sector, various Western and Northern European countries have not been able to recruit sufficient native-born workers for the formal care sector (Cangiano et al., 2009). The marketisation of the long-term care sector exacerbates the poor working conditions in the sector and stimulates employers to recruit low-cost migrant labour (Williams, 2012).

There is a strong association of paid employment with social citizenship. This has implications for the access to social rights, because in many countries paid work is increasingly a central requirement to access welfare and social security. Migrant care workers' attainment of citizenship rights is therefore circumscribed by their position in the labour market (Erel, 2012). "The way to achieve autonomy – to become a full citizen – is narrowed down to earning one's own income, that is, to become financially independent" (Knijn & Kremer, 1997: 350). Despite the low (economic) status of domestic work, it is generally valued when it involves the care for elderly or children (Cox, 2006; Hondagneu-Sotelo, 2001). Regardless of the social recognition of long-term care work, it is often not valued economically. "It is one thing to acknowledge the value and dignity of the work in theory, and another to pay for it" (Anderson, 2010: 66). It is important, however, not to restrict the framework to formal employment only: the reliance on, and presence of, migrant care workers is also shaped by the size of the underground economy, i.e. semi-legal employment (Lutz & Palenga-Möllenbeck, 2012). Da Roit and Weicht (2013) argue that the existence of an underground economy represents a favourable condition for the development of family-based patterns of care provision and, conversely, a non-favourable condition for employment of migrant care workers in the formal sector.

Anderson (2010) claims that it is important to recognise that migrant care workers are not mere "passive recipients of citizenship" (p. 63) but can actively *make* citizenship. Migrant care workers may demand rights and try to get engaged in the polity by public negotiation. Labour union involvement helps migrant care workers to claim legitimacy as political actors. The acceptance of membership by labour unions, despite the immigration status of migrants, can give a boost to the status and organisation of migrant care workers (Anderson, 2010). Migrant care workers' representation by trade unions provide information on the extent to which trade unions across EU countries recognise migrant care workers as 'workers'.

To summarise, with respect to employment regimes this present report will focus on labour market characteristics through which migrant care workers are channelled into specific jobs (cf. Williams, 2012; Da Roit & Weicht, 2013): the occupational roles that are distinguished within the LTC systems, the educational qualifications that are required LTC workers, the extent to which employment in private

households is regulated by the state and the extent of mobilisation of migrant (care) workers through trade unions.

1.3.3 Migration regime

In addition to care arrangements and labour market divisions, the national migration regimes play an important role in determining migrant work patterns too and in identifying migrant care workers' citizenship rights. For example, even though the interplay of the care regime and employment regime – e.g. private care provision combined with limited regulation of caring occupations – could potentially stimulate the hiring of the migrant care workers, this is unlikely when policies regulating the entry and residence of third country nationals (TCN) aim at reducing the inflow of unskilled migrant groups. National migration policies play a vital role in explaining the number of migrant workers in a country as well as understanding the occupational variation of migrant care work (Devitt, 2011). Drawing on Sassen's (2007) work, a migration regime is understood as a complex interrelation between migration policies, social, economic, historical and cultural circumstances of particular national regimes and the regulation and institutionalisation of migrant labour.

Countries may assess the desirability of specific migrants, among others, by their education level, their salary, or their indispensability to the economy. The citizenship rights that can be exercised by migrant care workers depends on the requirements that they have to meet to secure their entry and residence rights and the extent to which the residence rights are related to their (prospective) labour-market status. In this context Williams (2012) refers to special arrangements such as quotas for care and/or domestic workers and the existence of privileged-access policies for knowledge workers, including qualified nursing work. One must recognise that historical trajectories and relationships account for large part for the composition of the population of migrant care workers. Historical (e.g. post-colonial), economic and cultural links often play an important role in migration trajectories of migrant care workers (Tholen, 2009; Williams, 2012).

In terms of access to social rights, migration policies define whether or not, and under which conditions, migrant care workers can participate on the labour market. Naturalisation policies define who can acquire citizenship. 'Naturalisation' enables a foreigner to transform into a citizen. Countries vary considerably in the selectivity of their naturalisation processes. Because of the different migration regimes it is easier for migrant care workers to naturalise in one country than in another. Strict eligibility criteria, including residence and income requirements make the accessibility of citizenship more difficult. Particularly less educated or low-skilled immigrants may be deterred more easily by the seeming complexity of the naturalisation process (Vink, Prokic-Breuer & Dronkers, 2013). However, Vink, Prokic-Breuer and Dronkers (2013) also argue that acquiring destination-country citizenship has a much higher potential pay-off for migrants coming from low-income countries than for those migrants

originating from more developed and prosperous countries. They show that more accessible citizenship policies matter *less* for migrants from highly developed countries, but matter significantly for those originating from less developed countries. This raises questions about the impact of migration and citizenship policies on low-skilled migrant care workers from less prosperous countries. It seems to suggest that more accessible citizenship policies in destination countries function as a pull factor for low-skilled migrant care workers from less prosperous countries, because of the higher pay-off for these migrants. Yet, at the same time it is suggested that complex and restrictive naturalisation policies may function as a deterring factor for low-skilled migrants.

"[T]he legal framework set by the citizenship laws in the countries of origin and destination provides the opportunity structure with regard to access to citizenship" (Vink, Prokic-Breuer & Dronkers, 2013). These 'opportunity structures' are crucial for our understanding of the phenomenon of migrant care work. It is important to find out which categories of migrants can naturalise and under what conditions. Moreover, one needs to consider the country of origin and recognise the different channels and routes of migration (e.g. work-related migration, family reunion, privileged access as knowledge worker) (Kofmann, 2012). In short, the migration regime defines migrant care workers' possibilities in terms of labour market participation and position on the labour market, the possibility to naturalise and, ultimately, the accessibility of citizenship rights. In the present report, the institutional opportunity structure for the acquisition of citizenship for migrant care workers is defined by the level of selectivity and conditionality.

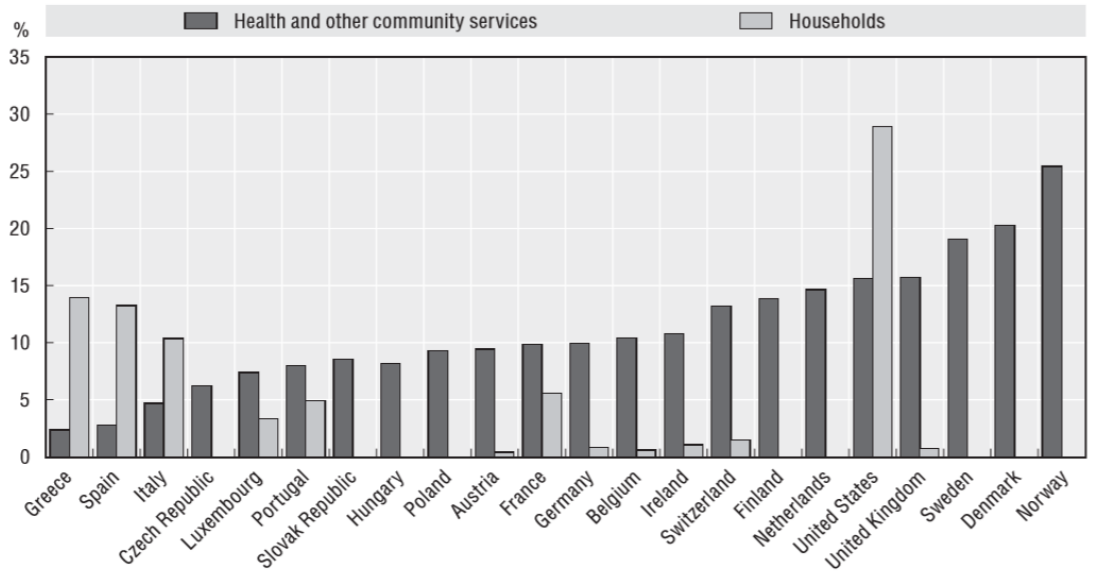
2. Reliance on migrant care workers

Within the occupational structures of European labour markets the care sector is expanding rapidly. Almost one fifth of jobs created across the European Union (EU) between 1995 and 2001 were in health and social services, reaching almost 10 percent of the total labour force (Eurofoundation, 2006). Lister et al. (2007: 132) point out that the care sectors' workforce are no longer confined to national boundaries:

> "*Migration into the care sector is rapidly becoming one of the key factors redefining care regime classifications, introducing a transnational dimension to a field that is mostly viewed as a national phenomenon*."

Despite this trend of the increasing prevalence of, predominantly female, migrant care work, the presence of migrant in the national care sectors varies considerably among countries (Figure 2.1). In the present section the reliance on, and prevalence of, migrant care work in Croatia, Denmark, Hungary, Italy, Spain and the Netherlands and Israel is discussed.

Figure 2.1 Employment of foreign-born in health and other community services and households (share of all foreign-born employment, 2005-2006 average)



Source: OECD (2011: 177). European countries: European Community Labour Force Survey (data provided by Eurostat); Japan: Labour Force Survey; United States: Current Foreigners Population Survey, March Supplement, reported in: OECD International Migration Outlook (2008).

2.1 Prevalence of migrant care work in Spain, Italy and Israel

In the Southern European countries, and also in Israel, migrant workers represent a large part of the workforce of the care sector. In Spain, the size of the household and home care sector is considerably higher than in most other European countries, and the migration processes have been the key of their growth (León, 2013). In a very short time-span, Spain has passed from being a country with one of the lowest participation rates of foreigners in the labour force at the beginning of the 1990s to become, by 2004, a country with one of the highest presence of foreign-born workers in the EU, not only in relation to care sector, but also in relation to national workforce. Net migration in Spain increased from 1.5 in 1993 to 17.6 in 2003, the highest figure for the EU-25 for that year (Eurostat, 2005). According to León (2013), the total growth of the Spanish domestic sector, from 221.500 individuals in 1996 to over half a million since 2005 (Ministry of Labour and Immigration, 2009) is solely explained by the influx of foreign-born workers (mostly female) into the sector. While in 1996 foreigners represented 6.9 percent of all those employed as domestic workers, the figure has gone up to over 50 percent since 2004, and in 2009, 63 percent of all domestic workers were non-nationals (INE, 2009).

In Italy, while incidence of foreign residents on the national population at the end of 2013 was 8.1 percent, the situation in the care sector is completely different. The statistic observatory on domestic labour (INPS, 2013) provides annual figures on the composition of professionals employed in care sector. In 2013, the Italian workers account only for 20,7 percent on the total domestic workers, while the share of Italian workers among the live-in care workers is only 15,3 percent. Moreover, one has to keep in mind that these data only refer to the workers who are employed legally, leaving aside the large part of non-national care workers employed through informal and irregular arrangements. According to Interlinks project estimate, the level of 'irregular' work in family assistance remains high: out of the about 770,000 foreign women working as family assistants in Italy, only one third is regularly employed (Di Santo & Ceruzzi, 2010).

Similarly, the growth in the number of migrant care workers coming into Israel is significant. Data are imprecise, but it is estimated that in 2010 there were approximately 54.000 migrant care workers, compared to approximately 8.000 in 1996 (Kav LaOved 2010). A governmental committee estimates that migrant workers account for 50 percent of the workforce in home care sector (Ministry of Finance 2007). In 2014, migrant care workers made up more than 60 percent of the total number of labour migrants (Asiskovitch, 2013).

2.2 Reliance on migrant care work limited in the Netherlands, Denmark, Hungary and Croatia

In the Netherlands and Denmark the figures suggest that migrant workers play a minor role in the care sector compared to the Southern European countries and Israel.

In the period 2000-2004 – a period in which the Dutch labour market was still characterized by shortage of healthcare personnel – only 638 foreign nurses and care assistants obtained a work permit (Van Baalen et al., 2009). More recent data on the reliance on migrant workers in the LTC sector is scarce and no data are available on the inflow of migrant care workers by nationality. Existing data fluctuate in terms the estimated number of foreign/migrant workers in the Dutch LTC sector. Fujisawa and Colombo (2009) suggest that eight percent of the Dutch LTC workforce consists of foreign-born workers. According to Van der Aalst and Van Uitert (2013), in the period 2009-2010, the inflow of migrant workers in the Dutch care sector was 1 percent, compared to 3 percent in all sectors of the labour market. This mainly concerned low-skilled work (i.e. care helps, level 1). According to the central Bureau of Statistics (CBS) the number of foreign-born workers[6] in the Dutch health and care sector was 875,000, which amounts for 7,7 percent of the employees in this sector (CBS, 2012). Da Roit and Weicht (2013) estimate the number of first-generation migrant workers in the LTC sector in the Netherlands to be about 12 to 13 percent. Considering a LTC workforce of 250,000 units, they produce an estimate of 33,000 foreign-born long-term care workers.

In Denmark a SFI study conducted in 2011 (Omsorg og etnicitiet (Care and Ethnicity), 2011), showed that the majority of migrant care workers come from other Nordic countries. TCNs citizens from the Middle-East, Africa and South-East Asia constitute the second subgroup of non-national care workers, whereas Eastern Europeans represent a minority. According to this study an important share of care workforce is composed of second/third generation descendants of migrants, who have been born in the country, and generally characterized by a low level of education (ibidem). A broad approximation based on the data provided by FOA (the Danish union for social and health service workers) suggests that non-national care workers represent between 7 percent and 12 percent of the total employees of this sector.

A similar situation can be found in countries in which the internal economic and labour conditions are less attractive for foreign citizens. In Hungary and Croatia the demand for migrant workers is, in general, limited and the overall share of migrant employees is very low. Hungary is primarily a sending and a transit country for migrants in the EU and has a very low number of migrants in the population. In 2010 only 1,5 percent of entire population was non-Hungarian citizens. Nevertheless, as wage differentials between Western and Central and Eastern Europe (CEE) countries become more moderate, CEE nations like Hungary are increasing their attractiveness for migrant in domestic home. In Croatia there are no sensitive data available on the proportion of non-national care workers in the elderly care sector, since the Ministry of Social Policy and Youth does not provide information on migrant care workers in its

[6] For the Netherlands, the formal nationality of immigrants is a far from satisfactory manner for gaining insights into the non-Dutch population, because a relatively high number of immigrants have acquired Dutch nationality. Besides, many immigrants from the former Dutch colonies (Surinam, Netherlands Antilles) already had Dutch nationality.

statistics. In general it is possible to assume that there are very few migrant workers in this field, as well as in the other employment sectors, since, according to the Croatian Bureau of Statistics, at national level the incidence of foreign citizens is only 0.53 percent.

3. CARE REGIMES

3.1 INTRODUCTION

Perhaps the most crucial questions regarding a country's long-term care (LTC) system are, 'is access to affordable and good quality long-term care services recognised as a *social citizenship right* and is long-term recognised as professional wage labour?' Answering these questions improve our understanding of the citizenship rights that citizens can exercise as potential care receivers, and, subsequently, the rights migrant care workers can exercise based on their position in the labour market. National care arrangements circumscribe the extent to which citizens have access to affordable and good quality (professional) care. The organisation of LTC systems, including the distribution of care responsibilities among the public and private sphere simultaneously define the framework in which the (migrant) care workers operate, and consequently affect their labour market status. Public care arrangements in which LTC is recognised as professional wage labour that must be provided by trained professionals, ensure that those employed in the sector have access to nationally available social security benefits. In family-based care arrangements, on the contrary, the rights of care workers are circumscribed by the family-worker relationship and are not enforceable, as is the case in the state-citizen relationship. So, national care regimes reflect the different stratification of the labour force in the care sector across countries and, subsequently, vary widely in terms of recognition and integration of the migrant care workers, and hence their citizenship status.

This section analyses the right to receive affordable and adequate care as well as the rights migrant care workers can derive from their position in the care sector. We will focus on four specific aspects of the LTC system: a) distribution of care responsibilities, b) the organisation of service provision; c) the structure of the care market, and d) the role of cash benefits. In the final part the framework by Knijn and Verhagen (2007) will be used to analyse how the dominant "logic of care" affects the (labour market) position, and role of, migrant care workers in each country.

Table 3.1 Use of key terms

Throughout the report, '**long-term care**' (LTC) is meant as a synonym for elderly care. Within the EU definitions of long-term care vary. According to the OECD, LTC "brings together a range of services for persons who are dependent on help with basic Activities of Daily Living over an extended period of time" (EC 2008: 3). Basic medical treatment, home nursing, social care, housing, transport, meals, occupational assistance and help with managing one's daily life, are included in this definition (Bettio & Verashchagina, 2010).

'**Formal LTC provisions**' are defined as services *supplied* by (professional) caregivers against a regular salary. These costs may, or may not, be (partly) collectively/publicly funded. '**Informal LTC provisions**' are services *supplied* outside any formal arrangement by private providers, including care provision by family, friends or other lay-persons. Informal care can be financed privately or (partly) publicly, for example the form of cash benefits. So, a distinction is made between formal and informal care *provision* and private or public *funding*.

The term '**qualified formal care workers**' "stands for trained and qualified professional workers who work for a regular pay in the LTC occupations. They are also referred to as care workers and professionals and include all levels of skill, from home helpers, to personal and social care workers, assistant nurses, therapists and nurses" (Bettio & Verashchagina, 2010: 62). '**Unqualified formal care providers**' are caregivers – including family, friends or migrants-in-the-family – who have *no educational qualifications* to provide care services, but have nonetheless a formal contractual arrangement and receive a regular salary for the services that they provide. '**Unqualified informal care providers**' are care givers – including family, friends or migrants-in-the-family – who have *no educational qualifications*, who have no formal contractual arrangement and who *do not* receive a regular salary for the services that they provide,, but may nonetheless receive informal payments.

For the sake of simplicity, comparability and consistency, the term '**migrant care worker**' is meant to encompass migrants[7] from *within* the EU (i.e. people working in a EU country other than their own) as well as Third Country Nationals, from *outside* the EU, working either in the formal or informal care sector.

[7] "(D)efinitions of who is and is not a migrant (…) are not cross-nationally consistent. This distinction can be important when the care workforce is comprised of both recent migrants and second or third generation minority ethnic groups" (Williams, 2012: 365). Depending on data available, in this report 'migrants' are alternatively defined as a foreign national, as foreign-born or as a native having a foreign-born parent.

3.2 Distribution of care: formal versus informal provision

In Italy, Spain, Hungary and Croatia LTC policies have long assumed the family to be the most important caring agency (Bettio et al. 2012; Leon 2013; Barta et al. 2014), both in terms of providing care, but also in terms of the funding of care services. In these countries the family role is also reinforced by the legal family obligation to take care of their dependent elderly. In particular in the Southern European countries the limited capacity of the formal care sector to provide in-kind services[8] and the necessity to respond to the growing unmet needs of care services have generated a shift from a 'family model' to a 'migrant in the family model' (Bettio et al., 2006; Naldini & Saraceno, 2008). In Hungary the 'familialistic' approach is even more institutionalised than in the Southern countries (Szikra, 2014). The families represent the main care agency, and the majority of the elderly care is arranged within households by family members. On the other hand, the lack of formal care[9] and the recent social changes that are affecting the family role in the care process – increase in women retirement age and their employment rate – opens space to informal care activities for migrant care workers who generally are employed outside the formal sector. The Croatian approach to care for older people is similar to the Hungarian one, but the care arrangement is even more directed towards family responsibility. Care for older people in Croatia relies heavily on the informal sector as the state plays a relatively small role in this sector, both in terms of financing and providing care services[10] (Podgorelec & Klempić, 2007; Mrnjavac, 2010). Since its establishment, the main goal of the Israeli LTC system has been to ease the physical and emotional, as well as financial burden of caring for older family members, not to substitute for the family as a prime source of care giving (Asiskovitch, 2013). In line with this statement, in Israel, the direct provision of public-funded services is ensured up to a certain level of disability[11]. Above this defined level, the responsibility of care is shifted to the family, and the public role concerns the provision of subsidies to private agencies that provide services mainly through foreign workers. The underlying philosophy of the Dutch LTC system is that the state bears the responsibility for the elderly and others who are in sincere need of long-term care. A similar rationality can be found in the Danish LTC system. The state responsibility model is a characteristic of the Scandinavian countries, including Denmark (CESEP, 2007; Schulz, 2010). The primary role played by the public actor in the management

[8] According to OECD the share of beneficiaries of formal in-kind services in both countries is below the EU average value: respectively in Italy and Spain around 6 percent and 7 percent of population aged over 65 receive formal services.

[9] According to Hungarian Central Statistical Office (CSO, 2008), in 2007, around 4 percent of the nearly 2.2 million persons at age 60 or older received home or residential care from professionals.

[10] In 2009, only less than 3 percent of the population aged over 65 received formal service (in-kind or in cash) (Rodrigues et al., 2012)

[11] The intensity of in-kind services publicly provided vary from 5 to 18 hours per week, based on the level of disability of dependent older people, their age and by the availability of family support. Above this level of intensity, the in-kind service is translated into a public subsidy paid to third private agencies which provide intensive services mainly through the hiring of guest care workers. In other words, the families that require intensive services have to arrange the care via private operators, and they receive a public subsidy in order to compensate a part of the care cost.

of care sector, which is also testified by the high level of public *spending*[12] and service *provision*, has resulted in a different structure of the care market compared to the previously mentioned countries, especially in relation to the role of migrant care workers. In Denmark and in the Netherlands it is hard to identify a niche of non-national care workers.

To summarise, in Spain, Italy, Hungary, and Croatia long-term care provision takes place mainly in the informal sphere due to the absence of a well-developed formal LTC system, whereas the availability of formal services dominates over informal care provision in the Dutch and Danish care sectors, while, in Israel the provision of services is arranged by private agencies in a context of shared responsibilities between families and state. Table 3.2 provides an overview of the coverage rates of formal care provisions. Table 3.3 provides data on public spending on long-term care services. The higher spending on long-term care services in Denmark and the Netherlands indicate that LTC provision is considered – more than in Israel, Hungary, Italy and Spain – to be a public rather than a private responsibility.

Table 3.2 Coverage rates formal care provisions: residential care and home care

	Residential care[13]	**Home care[14]**
Croatia	2. %	1.2%
Denmark	4.5 %	20 %
Hungary	3.2 %	4.9 %
Israel	3.0 %	20 %
Italy	3.0 %	4.9 %
Netherlands	6.3 %	21 %[15]
Spain	2.4. %	4.7 %

Source: own elaboration using (Rodrigues et al., 2012).

[12] In the Netherland and Denmark, the public spending level of the sector of care for older people, is almost or more than the double compared to the others countries involved in this report (Rodrigues et al., 2012).

[13] Coverage rates for residential care, people aged 65 years and over.

[14] Coverage rates for formal home care, people aged 65 years and over.

[15] The coverage rate for home care in the Netherlands is drawn from Statistics Netherlands. In this report, long-term care is defined as production of care provided by home-care organisations and nursing and care homes.

Table 3.3 Spending on long-term care as a percentage of GDP in 2010, subdivided into residential and home care

	Residential care	Home care
Croatia	-	-
Denmark	1.4 %	3.0 %
Hungary	0.3 %	1.6 %
Israel	-	-
Italy	-	-
Netherlands	2.6 %	2.4 %
Spain	0.7 %	2.4 %

Source: OECD http://stats.oecd.org/index. For Croatia, Israel and Italy[16] no data were available.

3.3 Organisation of formal care services

3.3.1 Ownership formal care services

In relation to the distribution between formal and informal care an important aspect that has to be considered too is the division of service providers within the formal sector. As table 3.4 suggests, the role played by public, private non-profit and private for-profit providers differs significantly across the countries examined. In Hungary, Croatia and Denmark the majority of services are financed and provided by the state. Contrary, in Israel the provision of services is left to private for-profit providers, both in home care and residential care. While in the Netherlands the organisation and financing of the LTC system is a public responsibility, services are primarily provided by private non-profit organisations. In Italy and Spain, even though the state has a primary role in financing and organising formal care, the 'care-market-mix' is more pronounced than in the other countries, and the limited capacity of the public formal care sector has created space for private operators. In both countries more than two-third of providers are private for-profit or private non-profit operators. Although Israel and Denmark present a similar coverage rate of the home care sector (table 3.2), formal services are organised in a completely different way: whereas public provision dominates in Denmark, private providers dominate the LTC sector in Israel.

[16] In 2011, in Italy the aggregate expenditure for LTC in-kind services was 0,68 percent of GDP (NNA, 2013).

Table 3.4 Ownership providers formal long-term care services

	Public providers		Private non-profit providers		Private for-profit providers	
	Residential Care	**Home care**	**Residential Care**	**Home care**	**Residential Care**	**Home care**
Croatia[a] (1)	prevalent		limited		limited	
Denmark[a]	prevalent	70%	limited	0%	limited	30%
Hungary[a](1)	prevalent		limited		limited	
Israel[c]	9%	0%	37%	28%	54%	72%
Italy[b](1)	30%		50%		20%	
Netherlands[b](1)	0		80%		20%	
Spain[b](1) (2)	23%		24%		53%	

Sources: a) Allen et al. (2011); Barnett et al. (2010), b) country reports WP9, c) Asiskovitch (2013).
Note: (1) Only aggregate data for residential and home care available. (2) No clear distinction can be made between private providers in Spain – non-profit providers include all providers with a formal contract with the Autonomous Communities; private for-profit providers include those providers with an 'authorisation' only, i.e. all costs have to be covered by the individual client.

3.3.2 Residential care versus home care

Overall, among EU countries residential care plays a secondary role in the elderly care sector compared to the provision of formal and informal home care services (Pommer *et al.*, 2007). In Denmark, Israel, Italy, Spain and the Netherlands the formal home care sector is larger than the residential care sector in terms of number of beneficiaries. Exceptions to this image are Hungary, where the formal home care sector and the residential one reach more or less the same share of beneficiaries, and Croatia[17], in which there are more elderly citizens living in nursing homes than elderly benefitting from the home help scheme. In the Netherlands, 6.3 percent of the population aged over 65 makes use of residential care facilities, while the coverage rate for formal home care is around 21 percent. In Israel the gap is even more pronounced since the home care sector provides services to 20 percent of the elderly, whereas residential care reaches only 3 percent. In Denmark less than 5 percent of the population aged 65 or over benefit from residential services, while the share of home care coverage among the same population is around 20 percent. In Italy and Spain the ratio of the beneficiaries of LTC services between residential care and home care is, respectively, one in three and one in five; but the difference could be even higher since the data are based on formal sector capacity, leaving aside the large part of home services provided by migrant women in informal/irregular arrangements.

[17] In Croatia, 25.7% of beneficiaries of LTC services is institutionalized, while less than 2% receive care home services (Ministry of Social Policy and Youth, 2013).

A different picture emerges if data on spending on residential care and home care as a percentage of total expenditure on health is considered (Table 3.5). According to these data, Denmark and the Netherlands spend a considerably higher percentage of health expenditure on residential care compared to the other countries.

Table 3.5 Spending on long-term care as a percentage of total expenditure on health in 2011, subdivided into residential and home care

	Residential care	Home care
Croatia	-	-
Denmark	13 %	27.4 %
Hungary	2.9 %	22.7 %
Israel*	1.3 %	53.8 %
Italy	-	-
Netherlands	22.2 %	17.9 %
Spain	6.1 %	25.7 %

Source: OECD http://stats.oecd.org/index. For Croatia and Italy no data were available. * 2010 data.

3.3.3 Non-national care workers in formal care services

In several countries professionalised home care services represent a limited resource for the dependent elderly. In Italy and in Spain, they reach around 4 percent of this population, while in Hungary this share is around 2 percent. In these countries, also including Israel, the public care sector does not provide intensive services[18]. As a consequences, the majority of non-national care workers provides care and support to older people directly in beneficiaries' homes. Additionally in Israel the migrant care workers are bound to provide live-in care services. Since 2010, new regulations even stipulate that all guest care workers must work in a live-in arrangement (Shamir, 2013). In Denmark and the Netherlands the residential sectors reflect a high level of publicly-organised services provided by public (Denmark) or private (the Netherlands) organisations. In both countries, the residential care sector provides daily and around-the-clock services in residential homes or nursing homes to a large share of dependent older people (4.5 percent in Denmark and 6 percent in the Netherlands). If migrants are employed in the long-term care sector in these countries, it concerns employment in formal public (Denmark) or formal private (Netherlands) care providing organisations. Table 3.6 clearly demonstrates that in Denmark, Hungary and the Netherlands, foreign-born workers are employed in the formal sector, while in Italy

[18] See footnote 10.

and Spain migrants are over-represented in the informal care sector. Data on the employment of *non-national workers* in the formal care sector shows that in Denmark the migrant workforce represents a tenth of the total public employees in the residential and nursing homes (FOA, 2010), with a prevalence in the low-skilled professions. In the Netherlands this proportion is lower, although their distribution among professionals is similar to the Danish one[19]. This indicates the foreign-born workforce in the Dutch and Danish formal care sector consists mainly of foreign-born workers who have acquired Dutch or Danish nationality.

Table 3.6 Employment of foreign-born in formal care services and informal care services

	Employment in formal care services	**Employment in households**
Croatia	-	-
Denmark	21 %	0 %
Hungary	8 %	0 %
Israel		-
Italy	5 %	11 %
Netherlands	14 %	0 %
Spain	2.5 %	13 %

Note: share of all foreign-born employment, 2005-06 average. This does not necessarily imply it concerns persons who have migrated for work-related purposes. Data may under-represent un-contracted migrant care workers. No data available for Croatia and Israel.
Source: own elaboration using OECD (2011).

In spite of a significant increase in the number of nurses and care assistants employed in residential sector during the last decade (ISTAT, 2008), the common feature among the Italian regions, is the incapacity of this sector in fulfilling the high demand of services. The growth of residential workforce has mainly concerned the national workers, and to a lesser extent the (qualified) migrant care workers. Similarly in Spain, the residential services respond to the necessities of a limited share of potential beneficiaries (around 2 percent of population aged 65 or over), and the private operators account for half of the services provided (Imserso, 2010). In Israel, the majority of the care workers in institutional settings are national workers. Nevertheless, as in Italy, in the last decade migrants with a permanent permit to reside in Israel are entering in this field, but they are still underrepresented (Asiskovitch,

[19] In 2008, according to Geertz (2010), the share of non-national workers within residential care setting was about 5 percent, with a higher representation among the personal care workers (3,5 percent), and a limited percentage among nurses (1.8 percent).

2013). In Hungary and Croatia the residential sectors account for the majority (Croatia) or for a large share of elderly care services (Hungary), and the Hungarian care system involves a plurality of providers[20], these services are mainly publicly organised and provided by national care workers.

3.3.4 PRIVATE PROVIDERS VERSUS PUBLIC PROVIDERS

In Israel, the introduction of the Long Term Care Insurance Programme (LTCIP) (late 1980s) generated the development of what several commentators called the "LTC industry" (Asiskovitch, 2013: 6). In 2011 around one-third of provided hours of home care services was delivered by private for-profit companies. In the residential sector, private for-profit agencies account for 54 percent of service delivery and the private non-profit operators account for 37 percent of service provision. A similar arrangement concerns the Dutch LTC system. In the Netherlands there are also no government-owned care providers, and all providers are private, either non-profit (the large majority) or for-profit (Mot, 2010). Until 1 January 2015[21], under the framework of the Exceptional Medical Expenses Act (AWBZ), which covered both care at home and in institution, 32 regional care purchasing agencies had been mandated to buy care with public funding. Similarly, the provision of home help for domestic activities has been delegated to municipalities in 2007 under the Social Support Act (Wmo), which are responsible to purchase services for the beneficiaries residing in their competent area according to their own capacities[22]. In Denmark, outsourcing the provision of care for older people to a for-profit provider has occurred primarily within the domain of home help, but is also gaining ground in nursing home care, although to a far lesser degree (Bertelsen & Rostgaard, 2013). Private provision is used mainly for practical assistance, and is used much less often with personal care (Statistics Denmark, 2012), and even less in the case of residential services (Bertelsen & Rostgaard, 2013). In Italy and Spain, besides the development of private provisions in residential care services, important changes have taken place in long-term-care arrangements through the unexpected growth of a private-care market based on domestic work and female immigration. Unlike the Dutch and Israeli cases, such a process has developed outside any form of public management and coordination of services provision. In Hungary and Croatia the state remains the dominant actor, and services directly provided by public facilities or networks cover for the majority of the beneficiaries of care services for older people. In Hungary, in 2006 only 0,2 percent of the population aged over 65 in nursing homes lived in facilities owned by

[20] In Croatia, the network of social services responsible for residential provision includes county and national homes for elderly and infirm, family homes, social care institutions, organizations, religious communities and other physical persons.

[21] As of 1 January 2015, the Long-Term Care Act (Wet Langdurige Zorg, Wlz) has replaced the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten* - AWBZ). In doing so, activities of a curative nature, such as long-term mental health care including treatment and home care by community nurses have shifted to the Health Care Insurance Act (*Zorgverzekeringswet*, Zvw).

[22] Whereas the AWBZ provided a right to care, the Wmo commands delivery of tailor-made support. Under the Wmo, care is only awarded if the capacity of persons seeking care, among others their financial resources and social network, are insufficient.

private companies (Kovács-Papházi, 2008: 20), whereas, in Croatia, in 2007 more than 75 percent of recipients of formal services benefited from public provision.

3.4 CASH-BENEFIT SCHEMES

Cash-benefit schemes, or cash-for-care schemes, are a formal care arrangement meant to support people with long-term care needs. Cash benefits can be provided by the state to family caregivers, or to care receivers as a cash-for-care-allowance which can be used to pay formal or informal caregivers (OECD, 2013). Cash-benefit schemes may have differential consequences for the labour market stratification of the long-term care market, depending on their regulation. Some schemes provide relatively low allowances and expect the care receiver to contribute to the costs of care services. In other cases the cash benefit is only provided in case no in-kind services are available. Cash-benefit systems may reinforce a direct informal employment relationship between the care worker and care receiver. The existence of cash-for-care schemes may also lead care workers into self-employment. The introduction of an employer-employee relationship in a care setting may put pressure on the relationship between the care provider and the care receiver, especially when the care provider is a family member. Cash-benefit schemes may also increase the inflow of (non-qualified) migrant workers into the home care sector, as such schemes enable potential care receivers to choose and employ different kinds of care workers, such as family members, professional staff or migrant care workers (OECD, 2011; Simonazzi, 2009).

The importance and use of cash benefits vary considerably across countries. In Italy and Spain these benefits represent the main element of the elderly care sector. In 2011, in Italy, the main cash benefit (*indennita' di accompagnamento*) absorbed three-fifths of the total LTC expenditure (NNA, 2013), while in Spain, around a half of LTC services were provided through financial transfers (Imserso, 2012). Contrary, in Denmark, there are no cash benefits of importance in care provision for older people (Rostgaard *et al.*, 2011, p. 9). Since 2008, the Israeli government has experimented with a pilot program of cash benefits circumscribed to a few regions (9 out of 23) in substitution of home care services, and currently, only around 8 percent of LTC beneficiaries receive these services. In Hungary the principal (and only) cash benefit related to LTC is a care benefit scheme provided for a family member who takes care of a relative, and is very limited in terms of funding and eligibility. In Croatia, disabled persons that need continuous help of another person can apply for a care allowance regulated by the Law on Social Welfare. In the Netherlands, in response to the rapid increase of expenditure and users of the Personal Budget (PB) during the last decade – the cash benefit provided in substitution of in-kind care – the government has substantially restricted the eligibility criteria in 2014.

Italy is the only country among the selected cases in which the (main) cash benefit[23] is neither means-tested nor proportional to the person's level of disability. In the others countries the right to receive a cash benefit is mediated by the family and/or individual financial availability, and the benefit's amount is related to the needs of claimants and/or to the services that they require and need. Divergence can also be found in the level of regulation of the use of these services. In Italy, Croatia and Hungary, there are no particular mechanisms of control and restriction, and the beneficiaries are free to use the amount of cash benefits according to their wishes. In Israel, the entitlement to receive a cash benefit is limited to severely dependent elderly who are actually receiving services from a caregiver who is not a family member for more than six hours a day, and the service is intended to pay (a part) of in-home caregiver wage. In Spain, with the introduction of the *Ley de Dependencia* in 2007, three types of cash benefits have been recognised. The use of these benefits is bound to the purpose defined by the law: *i*) purchasing of services not publicly provided; *ii*) supporting family caregivers; *iii)* and hiring a personal assistant. In 2012, in order to ensure budget stability a Royal Decree-law (20/2012) has redefined the eligibility criteria towards a more restricted access[24], especially for the family caregiver's benefits. As González-Ortega (2013: 54) has noted, one unintended effect of the *Ley de Dependencia* has been that "the top provision in all of these (benefits) has concerned the benefit for [in-] home caregivers, despite its exceptional nature". In the Netherlands, the amount of the Personal Budget scheme depends on the assessed need for different kinds of care (nursing, caring, household activities) according to a national system of hourly tariffs, and the beneficiaries need to justify their expenses, whereas a small part of the budget can be spent freely (currently 1.5 percent). In order to acquire the care they need, budget holders can contract either care professional organisations or non-professional individual caregivers. Additionally, all family members can be contracted, including cohabiting relatives and spouses.

In general, the primary objective of cash benefits is to provide financial support for the older or disabled person to help meet the additional costs of needed care. How this aim is reached in each country depends on the features of cash schemes themselves. In Italy, the 'attendance allowance' represents a pay-off for the family of disabled older people, that can foster the informal care within the family as well as the employment of migrant care workers in households. In Spain the recent reforms seem to have limited the cash benefits capacity in supporting the family caregivers, promoting instead the

[23] In Italy there are two different measures: the attendance allowance (*indennità di accompagnamento*) and care allowance (*assegno di cura*). While the former represents the main element of the formal LTC sector, the care allowance, introduced in few regions, and within them, in few municipalities, it is provided by local welfare departments and /or Health Care Departments, on the basis of a mean test and highly selective criteria, which are highly heterogeneous across municipalities. The recent economic crisis has further reduced the local welfares capacity to provide these benefits, thus, for this reason, in the report, we focus mainly on the national measure.

[24] The Royal Decree-Law has introduced the following changes: i) in order to receive a caregiver family benefits, the relatives must have been living with the claimant for more than one year; ii) the State ceases to pay into Social Security for the family caregiver; iii) the access to right of people with low level of disability (degree 1) is delayed until July 1, 2015; iv) the cash benefits monthly amount has been reduced by 15 percent.

families role as employer of home care workers. In Hungary the cash benefit characteristics have a double consequence, fostering the family role as a caring agency, and keeping the formal LTC sector separate from the informal/irregular LTC sector. In Croatia, these measures help families in facing the costs of residential services or in supporting their relatives in the care process, and can be seen as a form of informal care financing. In the Netherlands, the goal is to provide more flexible and personalised care services through the introduction of the Personal Budget. The introduction of cash benefits has resulted in a process of re-familialisation of care, and in a significant increase of public spending on home care services. On the other hand, and contrary to Italy, in Spain and to some extent Hungary, the growth of a large underground sector of care workers did not occur, probably due to the high degree of regulation of the measure (Da Roit & Le Bihan, 2011). In Israel the main aim of the cash benefit scheme is to provide to the families' sufficient financial means in order to reduce their informal care support through the employment of (foreign) live-in care workers.

3.5 Long-term care as a citizenship right?

In this paragraph EU's citizens right to receive (professional) care is considered. Using a framework in which the care regime is analysed in terms of 'funding of LTC' (private versus public), 'provision of care' (formal versus informal). The way LTC is funded and the way it is organised reveals the 'logic of care' (Knijn & Verhagen, 2007) that is dominant in a country.

Figure 3.1 Connecting care regimes, logics of care and citizenship rights

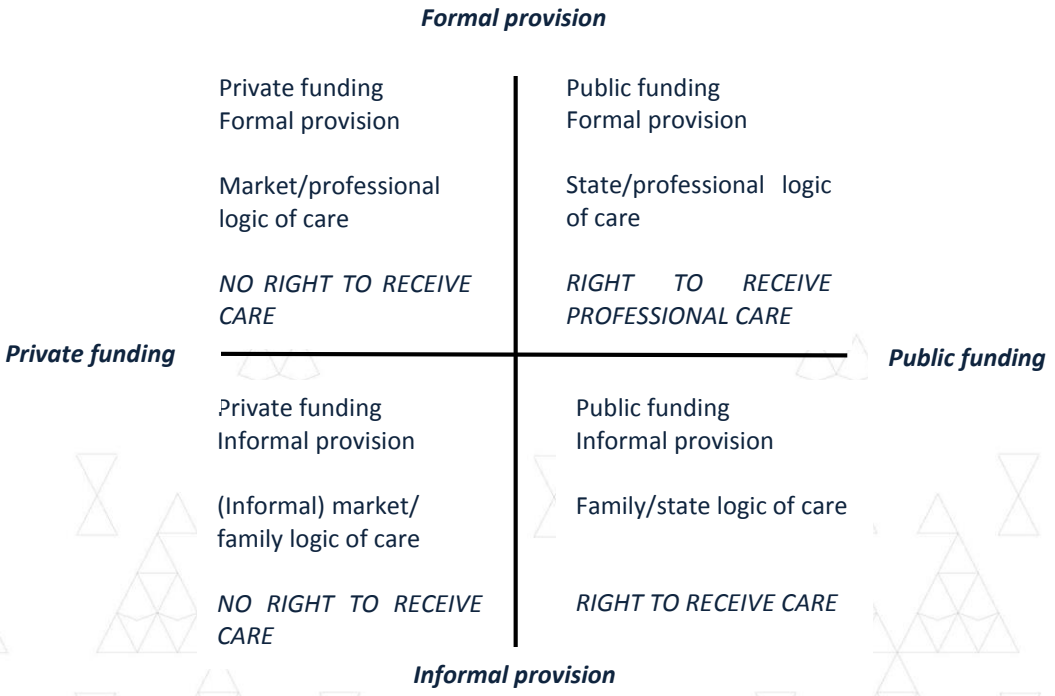
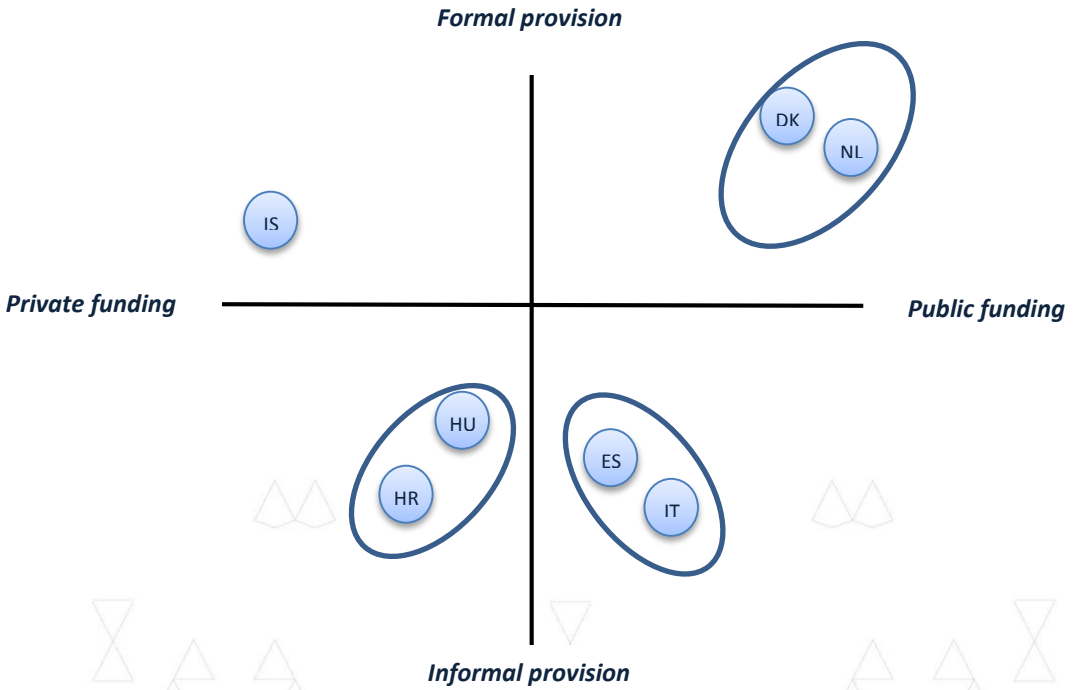


Figure 3.1 shows the right to receive that citizens can, or cannot, derive from the national care regimes and dominant logics of care. The care regime and the accompanying logic of care define the right of citizens to receive (professional) LTC services. Countries characterised by private funding of LTC services that are provided by formal private organisations rest on a market logic of care in which care is considered a commodity that is to be exchanged on a market by private and commercial – either professional or non-professional – actors. In such a system, citizens have no enforceable right to receive LTC services. Only those who can afford it have access to good quality care. However, such services may nonetheless be offered by professional care workers whose rights are protected by employment regulations. LTC systems in which the family logic prevails, services are (mainly) funded privately, or offered unpaid, and are provided in the informal sphere by non-professional workers, including family-members, friends or other laypersons such as (live-in) migrant care workers. Such a system may be characterised by a large underground economy, which may represent a favourable condition for the family-based patterns of care provision and/or informal employment of migrant care workers. Here too, citizens cannot claim to receive affordable and adequate LTC services as it is subjective to the informal caregiver-care receiver relationship; care provision is regarded as a 'moral obligation' in the eyes of the caregivers. The boundaries of the informal relationship decide who is legitimised to receive care. LTC systems in which services are funded publicly, but mainly provided by unqualified workers, are based on a combination of the family and state logic. The family and the state share the responsibility to care for those who need support in their daily functioning. Although the legislative state is responsible for the *funding* of LTC, informal caregivers (i.e. family-members, friends or other laypersons) are responsible for the *provision* of care. So, LTC services are not recognised as professional wage labour. Instead, the quality of care provision is disposed to skills and expertise of the members of the kinship group. Consequently, in such a care regime citizens have an enforceable right to receive informal care as are entitled to publicly funded help that is provided by *non-professional* caregivers.

Only in a care regime grounded on the professional/state logic citizens have an enforceable right to receive formal professional care. Here LTC services are funded publicly and are provided by formal professional care organisations. The state recognises care as wage labour and as work that has to be provided by trained, skilled and experienced professionals. Since cash benefits are a form of public funding aimed at supporting people in need of care, it can be considered as an extension of the citizenship right to receive care. Some schemes require users to hire from formal, registered agencies only. In those instances, cash benefits explicitly seek to improve access to formal professional care services. Yet, the right to receive cash-for-care benefits – either provided by formal organisations or by informal network – is often conditional because in most countries eligibility criteria are used to decide who has access to the cash benefit scheme.

Considering the division between public/private funding and between formal/informal care provision of the countries under study, it seems that the right to receive formal professional care is most developed in Denmark and the Netherlands. In the Netherlands it is added up by the right to receive informal paid care. Due to the absence of a well-developed formal LTC system where care is provided by qualified workers, and the residual character of public funding of LTC services, the right to receive professional care is less pronounced for citizens in Spain, Italy, Hungary and Croatia. Yet, the availability of cash benefit schemes in Croatia, Spain and Italy, enlarge the right to receive informal care. This is especially the case in Italy, where cash benefit schemes are unconditional and are not means-tested. The strict eligibility criteria for the cash-for-care schemes in Israel and Hungary, and the absence of cash benefits in Denmark, show that these countries do not seek to foster the right to receive informal care through publicly funded cash payments. Israel is located on the left end of the private/public axe and in the middle of the formal/informal axe, because of LTC services are largely privately funded and provided through private care agencies. Additionally, in Israel the family remains an important source for care provision due to the limited public expenditures on long-term care and the large responsibility for 'the market' in providing LTC services.

Figure 3.2 Long-term care systems across Europe



Note: DK = Denmark, ES = Spain, IT = Italy, HR = Croatia, HU = Hungary, IS = Israel, NL = the Netherlands

3.6 THE LOGICS OF CARE: POSITION OF MIGRANT CARE WORKERS

Several studies have suggested that the two main trends that affect the organisation of care regimes are an increasing recourse towards 'payment for care', and the expansion of home care services at the expense of residential sector (Da Roit & Le Bihan, 2007; Pavolini, 2008; Simonazzi, 2009). Moreover, these two elements are often identified as possible driving factors of the increasing number of migrant care workers in Western LTC systems (Ungerson, 2004; Bettio et al., 2006). Our analysis reaches similar findings. The main field of employment of non-national care workers, among the selected countries, is the (informal) home care sector. In addition, with the exception of Denmark and Israel, cash-benefit schemes represent an important aspect of the national LTC system and constitute a pay-off for the informal care provided by the families, or for the employment of a (non-national) live-in care worker. In order to analyse how the characteristics and orientation of the care regimes shape the citizenship status of non-national care workers, we have to pay particular attention to the organisation of the formal and informal home care sector.

To understand the conditions of non-national migrant care workers in terms of citizenship rights, and citizenship status, it is fundamental to analyse the logic that governs their role within the (home) care sector. Besides the three more consolidated "care logics", state, market and family, Knijn and Verhagen identified the professional logic of care, "based on its discretionary power, founded in a professional claim of distinctive expertise, knowledge, and skills" (2007: 463). At the same time, they recognise that because home care work is a semi-profession, it is — in contrast to "real" professions — neither fully established nor fully desired. Its professional expertise is much less defined than that of high-skilled professions (Etzioni, 1969). Consequently, home care may appear to be quite mundane or pedestrian and has a diffuse borderline with family or community care. In our opinion, the recognition of home care as a semi profession, and its unclear independence from family' tasks, provide useful insights in the analysis of the position of non-national migrant care workers.

In those countries in which the family care logic is dominant, as in the Southern and Eastern European countries, a professional logic of care hardly exists. In these countries the responsibility of care falls on families. Usually, non-native care workers provide services in an in-home setting as a substitute for, or in combination with, informal care arranged by family members or lay-persons. The recognition of (non-national) care workers depends on their substitution for or integration in the family as a care provider, not depending on the quality of the services provided nor on their expertise. The limited recognition of care worker's level of professionalisation is the basis of the mechanism that regulates the employment status of non-national care workers. In these countries the limited public support in care sector results in the necessity for families to seek for alternative and affordable LTC services, which are often provided by un- or low-skilled (migrant) care workers. In Italy and Spain this process is fostered by the 'cash-for-care' orientation of their national LTC systems: cash benefits represent a

supplement to the pension income to pay an (irregular) in-live migrant care worker. In Hungary and Croatia, where the recent increase of female labour participation has modified their role within the family as a principal caregiver, this process is less visible and intense, and non-national care workers are directed towards an integration into the family instead of substituting family-based care provision. In other words, a familialistic approach in the care regime and the dominance of a family logic of care preclude a full integration and recognition of the migrant care workers, affecting their citizenship status. The non-professional recognition of non-national care worker limits their activities to this field of employment, precluding career advancement and limiting their integration in the formal professional sector. Their employment arrangements are usually dependent on the families' economic sustainability that goes to the detriment of their formal recognition. Often the non-national care workers are employed through the 'grey' market without proper employment contracts, i.e. the employment in the underground economy. In these cases, non-national citizens are not entitled to receive fundamental socio-economic rights, as social contributions and unemployment benefit. Additionally, the 'irregular' condition of migrant care workers, and especially of the TNCs, hampers their settlement in the hosting countries, since the primary condition to apply for a residence permit is formal employment. Above all that, in Italy, Spain and in Hungary, the most prevalent care arrangement, i.e. in-home care, implies that migrant care workers cohabit with their employers, resulting in an unclear distinction between free and working time, and a significant reduction of personal independence.

In Israel, the expansion of the 'LTC industry' reflects a market logic of care. In contrast to the Netherlands and Denmark, presenting similar levels of coverage of formal LTC services, in Israel the partly publicly subsidised services are provided by private agencies[25]. The professional logic of care is subordinated to market principles: a segmentation of the formal sector, in which the degree of professionalisation of services is connected to economic resources of care receivers, rather than constituting a recognised right. This segmentation is clearly visible while looking at the position of non-national care workers in the care market. While professionalised care is provided by national workers, either employed publicly or privately, the remaining bulk of (formal) home care provision is left to migrant care workers, constituting a non-professionalised workforce bounded to operate in this sector. Similar to the EU Southern countries, the families' needs to receive affordable services, has led to a massive resort on migrant care workers by older people's families. Unlike Spain and Italy, the prevalence of the market logic of care in the Israeli care sector results in a formalisation of the employment arrangements of low-paid non-national workers. In Israel non-national care workers are generally included in the regular market – hired by private agencies – reflecting the recognition of LTC

[25] In these countries the difference of public involvement in the elderly care sector is clearly represented by the level of public spending. In Israel around 0.6 percent of GDP is dedicated to elderly care, while in the Netherland and Denmark this share is higher than 2.5 percent.

work as wage labour. Nevertheless, their working conditions, their career possibilities, their rights to reside and live in Israel, and thus their citizenship status, are limited.

The state logic of care characterises the Danish and Dutch LTC systems. In these countries the recognition of non-national care workers is based on the (semi-)professional activities that they provide – caring for older people – since the responsibility of care provision is a public matter. The elderly have a recognised right to receive professional LTC services. When the state and professional logics of care are dominant, migrant care workers are included in the formal sector because of their professional skills. In the Netherlands, the recent increase in the use of cash benefits (PB) has undermined the professional logic of care. This has resulted in the remuneration of the non-professional informal care provided by relatives, and not in an increase of the proportion of migrant workers within care sector. In Denmark and the Netherlands the non-national care workers constitute a limited share of the total care workforce, and although they are mainly employed in professions for which the lowest level of qualifications required, they benefit from the same social protection and employment rights as the national workers do.

4. EMPLOYMENT REGIMES

In order to understand how employment regimes affect the position and the citizenship status of the non-national care workers, it is important to focus on the following aspects of the member states' labour markets. First, the educational qualifications required for distinct occupations involved in LTC sector. Second, the process of recognition of the qualification of migrant care workers obtained in their countries of origin. Third, it is important to analyse the legal regulations for the employment of the migrant care workers (especially in home care), also in relation to the countries of origin (EU-citizens versus TNCs). Fourth, the role played by unions, in representing the national and non-national care workers. This could be a useful proxy for their level of recognition and protection. And finally, the degree of access to social services that migrant care workers have.

4.1 OCCUPATIONS AND QUALIFICATION REQUIRED

As set out in the first chapter, labour market stratification in the LTC sector mainly follows the categorisation into nurses, care assistants, home helps and, even though not present in all countries, live-in care workers. As in Appendix A, the category of nurses present a similar level of qualification required among the selected countries. In general, this profession is highly regulated and requires the highest educational qualifications; i.e. polytechnic/university degree. Exceptions concern the subgroup of 'practical nurses' in Israel, for which a partial course of approximately one year long is required. And Hungary, where most nurses have an undergraduate academic degree, while only few of them dispose of college degree. The final exception is Croatia, where the practical nurses generally have a basic training granted through professional medical high school.

The homogeneity among the educational qualification between countries is very limited when care workers and care assistants are concerned. Denmark and the Netherlands present the highest level of professionalisation of these professions (from 3 to 2 years of vocational training). In Italy, the care workers and care assistants are recognised by the profession of Health and Social care Operator (OSS). The profession of OSS is recognised nationally, but the Regional Authorities have the competence to organise specific vocational training (1.000 hours including about 50 percent on-the-job training)[26]. These initiatives are however quite episodic and piecemeal, and usually are addressed to the national workforce, and generally involve only a small part of care work immigrant supply. Similarly, in Spain the occupation of care worker requires a secondary vocational training. However, due to the large number of unqualified care assistants with sufficient practical experience, the government has recently introduced an obligatory Certificate of Professionalism (450h of training) for these workers. In Israel

[26] Lombardy Region
http://www.regione.lombardia.it/cs/Satellite?c=Redazionale_P&childpagename=Cittadini%2FDetail&cid=1213421176845&pagename=CTTDNWrapper

the training of care workers and care assistants consist of a short course prior to a work placement, or on-the-job training (120h). In Hungary, care assistants employed in the residential sector have to obtain an associate degree. In the home care sector, instead, the formal service called 'home help', does not require specific professional qualifications. In Croatia, care workers are expected to follow two different paths of qualifications. Care workers working outside the state system of social services must have a diploma from an officially recognised study program, while, care assistants need have at least completed elementary education and attain a certificate of training issued by one of the licensed training programmers.

Apart from Denmark and the Netherlands where domestic/live-in care workers constitute a minimal portion of care workforce, this category of the LTC labour market constitutes a category with similar characteristics among the selected countries. In Croatia, Hungary, Israel, Italy and Spain live-in care workers provide a significant share of LTC services. However, in none of the countries this occupational group requires any qualification or vocational training. The only exception is Spain, where live-in care workers need to obtain the 'socio-health home care certificate of professionalism' in order to be formally recognised.

The educational level of non-national care worker and the process that regulates the recognition of foreign qualifications can affect the migrant care worker's position within the LTC labour market, their working conditions, and thus the rights these workers can derive from their employment status. Directive 2005/36/EC on the recognition of professional qualifications ensures a high portability of qualifications for medical doctors, nurses and dentists (Peeters et al., 2010). According to this directive, EU professional nurses have a preferential channel for migration to other EU countries. Additionally, Italy, Spain, the Netherlands and Denmark, recognise a privileged entry route for professional nurses, including migrants from non-EU countries, that ensures a full recognition of their qualifications and thus of their profession[27],

On the other hand, in almost all countries involved in this study professional nurses represent a minority of the elderly care workforce (see Table 4.1), especially among non-national care workers. Therefore, it is relevant to focus on the process of recognition of qualification of the other LTC occupations. In Spain, the recognition of the most common qualification among the non-national care workers – the Intermediate Vocational Training – was limited[28]. This suggests that in this country, the recognition of

[27] In these countries the qualification of TCN professional nurses are assessed by separate process of recognition compared to the other care professions, which ensures a preferential channel of recognition similar to that one applied to highly-skilled workers.

[28] Focusing on three nationalities, Ukrainians, Polish and Filipino citizens, the number of IVT recognised was, respectively, 73, 7, 1.

foreign qualifications of migrant care workers does not represent a common practice. In Italy the procedure for the recognition of qualifications obtained abroad is complex and expensive, and tends to generate a process of 'downward assimilation'[29]. Generally, even though migrant care workers have on average a medium-high level of education, do not have any particular qualification for providing care work (Di Santo & Ceruzzi, 2010). The specific agreements between Denmark and the other Nordic countries[30], ensure a full recognition of qualifications obtained abroad by migrant care workers from Nordic countries. At the same time, Danish public integration policies strongly encourage employment of workers who already live in Denmark as second-generation immigrants). Professional schools offer preparatory courses for this segment of the population, so they can obtain the same educational level as their native Danish counterparts (Care & Ethnicity, 2011). In the Netherlands, the desirability of specific migrants is assessed, among others, by their education level, and their indispensability to the economy. The requirements migrant care workers have to meet to secure their entry and residence rights seem therefore very much related to their (prospective) labour-market status, and thus on the attractiveness of their qualifications for the Dutch state, economy and society. As a result, in the Netherlands, the status of highly-skilled employee that allows the entry of migrant care workers, could potentially apply only to migrant care workers who work as a nurses. This status does not apply to lower-skilled jobs such as domestic care workers or care assistants. While in Israel the recognition of tertiary education for professional purpose is a competence of the appropriate government offices that release a professional license after the evaluation of the congruity of the qualifications, the guidelines on the acceptance of non-academic titles are very strict[31]. As a result, in Israel non-national care workers are usually guest workers who do not have any particular qualifications in their country of origin, and who have not attended any training in the host country. In Hungary, the majority of migrant care workers in elderly care does not have any special qualification in medical or social care. In contrast to EU citizens, the qualification recognition procedure for TCNs is more complex, as their diplomas are not recognised automatically. In Croatia, the diplomas and certificates for care-work of EU citizens are recognised as being equal to the Croatian. Besides following formal education, the license of TCNs need to be acquired according to the Croatian regulations.

In summary, due to the high level of the professionalisation, nurses represent a separate and distinct occupational group within the LTCs labour markets. This professional status allows a secure entry for

[29] According to the National Institute of Statistic (ISTAT, 2008), about 40 percent of migrants with tertiary education and more than 60 percent of those with secondary education perform manual labour, in comparison with respectively 5 percent and 20 percent of Italians.

[30] Since 1950 The Nordic Region has had a joint labour market, and a similar educational system, which ensure to the citizens of the Nordic countries (Denmark, Sweden, Norway, Iceland and Finland, Faroe Islands, Greenland and Åland) very limited restrictions on obtaining work permits in each other's countries. http://www.norden.org/en

[31] http://www.nbn.org.il/

the professionalised non-national nurses, even in the case of TCNs. Thus, professionalised nurses tend to be regarded as highly-skilled migrant workers to which a preferential channel for entry in the EU countries and in the national (care) labour market is ensured. Less professionalised non-national workers, i.e. care workers and care assistants, experience a different process of migration. In the Netherlands, these workers are discouraged to enter the country since they are not recognised as a 'productive resource' for the national economy. Denmark encourages improvement of the level of qualification of the national workforce through preparatory courses that are particularly aimed at the inclusion of citizens with a low-educational status,, while ensuring a specific entry channel for the migrant care workers from Nordic countries. In Italy, Israel and Spain the professional level of non-national care workers seems to represent a secondary aspect in the migration process. In these countries the inclusion of the non-national care workers in the care sector is not so much based on their qualifications or professions, instead their inclusion in the LTC labour market is driven by the high internal demand for(unqualified) care work. Similarly, In Hungary and Croatia the level of professionalisation of the migrant worker plays a secondary role, since they are mainly employed in the informal sector.

The domestic/live-in care workers represent an opposite case to the professionalised nurses. Usually it is not required to have obtained any specific qualifications for these kind of caring activities and especially in those countries in which there is a complex process for the recognition of educational and professional level (Israel, Italy and Spain), the domestic care sector represents a broad segment of employment for non-national care workers.

4.2 Employment procedures for migrant care workers

In the six EU countries involved in this study the legal process required to employ EU migrant care workers does not differ from the legal process required for the employment of national workers. EU citizens enjoy the right of free movement and settlement in the EU (directive 2004/38/EU), and they experience the same obligation and procedures as nationals citizens. In the case of TCNs, the employment procedure is subordinated to the obtainment of a valid work and/or residence permit in all countries. As will be discussed in the next chapter, these permits are related to the claimant's economic independence in order to do not constitute a burden for the national social welfare systems, and to the desirability of their profession in relation to the national labour market.

In Netherlands, in order to access the labour market, highly-skilled non-EU care workers, or their future employer, who acts as a sponsor, have to apply for a regular provisionary residence permit (MVV)

and/or a regular residence permit (VV) in their name[32]. In the Netherlands, the list of recognised sponsors for migrant workers only includes two organisations providing long-term care (IND, 2015), indicating that the number of migrant care workers in long-term care categorised as 'highly-skilled migrants' is very limited[33]. In the Danish case, for citizens of a country outside the Nordic countries or the EU/EEA, the obtainment of a residence and work permit depends, first and foremost, on workers' qualifications. The Danish immigration rules envisage several special schemes designed in order to make it easier for highly qualified professionals to get a residence and work permit in Denmark. On the other hand, these rules cannot be directly applied to *all* non-national care workers, inasmuch these rules are targeted to attract highly qualified professionals.

Similarly, the number of work permits in Croatia is limited due to the system of work quotas. The work quotas are each year regulated by the governments and limited only to a narrow number of highly skilled workers (mainly doctors), of which care workers and care assistants are excluded. In Spain TCNs need to obtain administrative authorisation to work in Spain, either through the procedure of collective management of such authorisations in their country of origin[34] (through the Spanish embassies or consulates); or through the individual processing of the application for authorisation. In the latter procedure, the national employment situation is taken into account in the decision to grant authorisation. An additional option is represented by the special regime of residence and work of highly qualified professionals. However, care workers (i.e. home helps, care assistants and domestic workers) do not fit into any of those 'exceptional circumstances'.

In Hungary TCNs have to obtain a visa before entering the country. Even though there are no sectoral restrictions on the employment of migrant care workers in the Hungarian immigration laws, there is a restriction on the number of TCNs who can have access to a work permit. Additionally, similarly to the Croatian case, TCN citizens can only be employed officially in an organisation if the employer assures the local job center that the vacancies for which they plan to hire a foreign worker cannot be filled with a Hungarian employee. In Italy, it can be difficult for non-EU migrants to enter in the formal (care) market. Due to their precarious status, non-EU immigrants can hardly obtain a residence and entry permit. In fact, in Italy migrants' right to stay is linked to the condition of regular employment, i.e. work

[32] The following TCN are exempt from the requirement of a regular provisionary residence permit (mvv): Australia, Canada, Japan, Monaco, New-Zealand, Vatican City, the USA, South Korea. In their case their sponsor has to apply for a regular residence permit (vv). Additionally, to Swiss citizens the same conditions of EU citizens are applied.

[33] In the period 2000-2004 – a period in which the Dutch labour market was still characterized by shortage of healthcare personnel – only 638 foreign nurses and care assistants obtained a work permit (Van Baalen et al., 2009)

[34] Job offers made through this procedure will be directed preferably to countries with which Spain has signed agreements on the regulation of migratory flows, and these countries are Ukraine, Mauritania, Dominic republic, Morocco, Ecuador, and Colombia (art. 39.1 LO 4/2000; arts. 167-177 RD 557/2011). Nevertheless this option is not applicable to migrant care worker, since currently concerns only workers for seasonal agricultural campaigns.

regulated by a formal working contract, which is hard to achieve and maintain in the care (domestic) sector, where informality prevails (Caponio & Graziano, 2011; Scrinzi, 2004). In Israel, all foreign citizens are considered 'third country nationals'. Since there is no special channel of immigration based on nationality, the employment of non-national care workers is subordinate to the obtainment of a working visa. The visa is granted for a limited period of time and only for sectors open for employment of foreign workers (primarily care-giving for the elderly or the disabled, and in agriculture or construction). Non-national workers are entitled to work only in the sector for which the visa was released (Feller, 2004). Moreover, similar to the Croatian, Hungarian and Dutch cases, in order to employ a non-national care worker the employer has to prove that there is no Israeli available for the job, and has to provide information on the position, the proposed salary, and the professional qualifications required.

In summary, EU citizenship ensures migrant care workers from within the EU a facilitated procedure to access national labour market of EU member states, providing these migrant care workers with employment conditions that are comparable to the labor market status of national care workers. However, the case of TCNs migrant care workers is completely different as their citizenship status – not being a citizen of an EU Member State – implies that their labour market position varies across member states. Generally though, the possibility for TCNs to enter the selected countries, as well as the possibility to be employed in the national long-term care sector on a formal and regular employment contract is dually restricted: first, by their position as a *non-EU worker* (i.e. a TCN) and second, by their position as a *low-skilled worker*.

4.3 Employment structure in residential care

Table 4.1 indicates that among the selected countries the employment structure of the residential sector presents similar characteristics. The majority of employees is represented by care workers and care assistants, whereas the professional nurses represent only a minority. In all countries non-national care workers are mostly employed as care assistants, care helps or practical nurses, and only a small group works as a professional nurse. In the Netherlands, among the professional nurses the share of non-national workers is only 1.8 percent, while the personal care workers (i.e. care assistants) account for 3.5 percent. Similarly in Denmark, in 2010 among the professional nurses only 2 percent had a non-Danish nationality, and all the immigrant nurses were EU citizens. On the other hand, for the two professions that represent a lower degree of professionalisation, the proportion of immigrant workers was higher as well as the percentage of non-EU citizens, especially among the care assistants. In Italy, Spain and Israel, even if there is no clear information about the nationality of the non-national care workers, around 10 percent of residential workforce has a foreign nationality. In Israel, over the last decade immigrants with a permanent permit to reside in Israel have entered in the field of residential care, but they are still underrepresented, and are mainly employed as care assistants and practical

nurses (Asiskovitch, 2013). An exception seems to be the Italian case, in which the recent growth of the private residential sector has generated a demand for professional nurses that has been partially fulfilled by non-national worker (ISTAT, 2008). Despite that, it has to be considered that the private sector in Italian residential care is characterised by lower wages and less favourable working conditions compared to public residential care organisations. Completely different is the case of Hungary and Croatia, where the residential sector is precluded to migrant care workers, since the residential workforce is completely composed of national workers.

Table 4.1 Employment structure residential sector

Among the selected countries, besides the managerial and administrative staff, the professionals involved in residential care can be broadly attributed to two categories: Specialist medical staff – geriatrics, physiatrists, general practitioner – and nurses and care assistants. Care assistants represent the most important field of employment for non-national care workers. The ratio of nurses and care assistants, even though it varies between the examined countries, suggests a similar trend. In **Italy** and **Spain** care assistants constitute the largest part of the residential workforce. In Spain, for example, the autonomous community of Catalonia carried out annual calls for the accreditation of collaborating entities in their programmes of social services. These calls specify the types of professionals and the hours of dedication that have to be undertaken for each user of residential services. Depending on the user's degree of dependency, an elderly care worker has to provide from 400 to 580 hours/year per user, whereas a graduate nurse is involved only from 37 to 70 hours/years per user. In **Israel**, approximately 70 percent of the staff in residential institutions is comprised of care assistants, with only 30 percent of professional nurses, and within the nurses group, the majority is represented by practical nurses (The Ministry of Health, 2006). **The Netherlands** presents a slightly higher level of professional nurses in the institutional sector, in fact these professionals account for 38 percent of the residential care workforce (OECD, 2011). In **Denmark,** the nursing homes' personnel mainly consists of the so-called 'social and health service assistants' (SOSU-assistenter), social and health service helpers (SOSU-hjælpere) and nursing home assistants**.** There are 43.500 employers working on Denmark's about 1.300 nursing homes. Of these 1.456 (3.5 percent) are nurses, 9.848 (22.5 percent) social- and health service assistants and 19.225 (44.5 percent) are social and health service helpers (Kommission om livskvalitet og selvbestemmelse i plejebolig og plejehjem, 2012). In Croatia, nurses and other medical staff make up the majority of employees in state care institutions, while care assistants work mostly in non-state institutions, such as retirement homes. Or they work privately as individual care assistants. According to the annual statistics on employees in social welfare institution of 2013 Ministry of Social Policy and Youth, the structure of nursing home homes (including public and private providers) is as follow: more than one-third consists of care assistants (2.288) and around a quarter is represented by nurses. Similar outcomes were found in Hungary. According to the Ministry of Health, Social and Family Issues, in 2002 (latest data available), most care workers in the institutional care field were either general and specialised nurses or care assistants.

4.4 EMPLOYMENT STRUCTURE DOMESTIC CARE WORK[35]

The working regulations of domestic care workers tend to differ among countries. Not only in relation to rights and social protection ensured, but also in relation to the specific professions to which regulation are applied. In the Netherlands and Denmark domestic helpers as well as live-in care workers constitute only a limited share of the long-term care workforce, and the regulation of domestic care work mainly concerns professions that provide domestic chores and non-professional care for older people and children. On the other hand, Spain, Italy and Israel recognise specific working regulations of domestic care employment that embrace both domestic help and non-professional services. In these countries the reliance on live-in care workers is a common feature of the care regime. In Hungary the domestic care work regulation does not differ between professionals involved in this field. Neither is there an official job contract that regulates the working relationship between the two parties, i.e. the family and the care worker. Similarly, the Croatian employment procedure does not differentiate between home care workers and in-home care workers. Usually domestic care work is regulated by individual personal relationships between caregiver and the care receiver, rather than by an official working regulation.

In the Netherlands, in order to make a larger proportion of domestic care work of private persons visible to the authorities, a new type of regulation was implemented in 2007 (*Regeling dienstverlening aan huis*). The new regulation implies that a private person can hire another private individual for domestic work up to a maximum of three days per week with no obligation to pay taxes or social security premiums. So, domestic care workers working on that basis are excluded from social security benefits and they are covered only by legal minimum standards regarding wages, vacation allowance and paid sickness leave. In Hungary, the Law on '*Certain Economic and Financial Activities*' of 2010 that regulates the domestic care work, eliminates the employer's responsibility to provide social security contribution, excluding the possibility for domestic care workers to have access to health care services and retirement benefits. In this country, additionally in-home care is tax free for both employer and employee: households employing care workers only have to pay a 1.000 Fiorint (about 3 Euro) monthly registration fee to the Hungarian tax authority. In Denmark, domestic care work mainly concerns the work of au pairs. Even though the scheme regulating this occupation was created as a way to provide young people with a cultural exchange opportunity. Yet, the programme has been highly criticised due to the labour exploitation of the migrant women. In order to improve the working conditions of these

[35] In this report, the analysis of employment procedures in the home care sector focuses on the subsector of domestic care. This decision is based on two considerations. First, the employment structure of the formal home care sector tends to reflect the residential sector one, i.e. the majority of the workforce is composed by care assistant. Second, the characteristics of domestic care work in some countries (high level of informal working regulation and live-in care arrangements) require a separate analysis in order to understand how the national working regulations condition the employment rights and the position of domestic care workers.

workers the Danish government has recently modified the scheme that regulates this occupation; introducing the necessity of a written contract among the parties, a minimum salary, and the obligation for the host family to cover the insurance costs for the au pair. In-home care workers in Israel, whether Israeli residents or migrants, are covered by every article of protective employment legislation, except overtime compensation. According to the Ministry of Industry, Trade and Employment, live-in care requires the presence of the worker for 24 hours a day all week long. In practice, however, because the Ministry of Economic and the Ministry of Interior are not able to supervise the working conditions in the in-home sector because services are provided in the receivers' households, foreign workers' rights are often abused. This has a detrimental impact on their wages, social benefits and working conditions (Natan, 2011; Shamir, 2013). In Croatia the only provision in the Law on working regulations in domestic care states that workers should not work more than 40 hours a week. On the other hand, residence as well as employment conditions between the two parties are not specified. This means that levels of remuneration, work and living conditions, as well as work-related rights, such as social contribution for health and pension schemes, are left unregulated.

In Spain, domestic care employment is considered as a special working relationship, and is regulated by the Real Decreto (Royal Decree) introduced in 2011. In comparison with the previous Royal Decree of the years 1985, the 2011 decree has led to a substantial improvement of the conditions of domestic helpers. It has led to a progressive equalisation of the working relationship, comparable with those established within regular labour agreements[36]. This regulation has improved the rights for domestic workers, ensuring greater employment stability through the elimination of the annual temporary non-occasional contracts and adherence to the rule of Workers' Statute (common regulations) regarding temporary recruitment. Additionally, mechanisms have been introduced to strengthen transparency, such as the prohibition of discrimination for access to employment and in the obligations of the employer to inform the home employee of their working conditions. Besides these improvements in terms of rights and social protection, the decree has had a substantial positive effect on the reduction of undeclared workers: the number of domestic workers registered for social security has more than doubled between 2012 and 2014[37].

In Italy care work in the private household is regulated by the National Contract for Domestic Workers (NCDW), which unlike the previous countries, regulates all the aspects and activities concerning the

[36] Among others, the Royal Decree ensures that the workers' salary has to be paid monetarily and in proportion to the working day, at a rate not less that national minimum wage. From January 1, 2012, domestic helpers are integrated into the General regime of the Social Security. The regulating of the timetable are regulated by both parties, rather than just by the owner of the family home. Rest time between working days has also been increased, and the legal regime of holiday has been improved (Royal Decree 1620/2011).

[37] *Ministerio de Empleo y Seguridad* Social, Data are available at http://www.empleo.gob.es/series/

occupations of domestic helpers/domestic workers and unqualified and qualified live-in care workers. The NCDW regulates the working conditions and provides a broad coverage of employment rights. The working schedule has to be agreed by the parties, with a maximum of 54 working hours per week. Live-in staff are entitled to at least 11 consecutive hours of daily time off, and to 36 hours per week of rest. The contract recognises the possibility of overtime work, and it even formalises the overtime payment to domestic workers. After one year of employment , the domestic worker is entitled to a paid holiday of 26 working days, and to a sickness leave of 15 days. Maternity leave is also recognised for a length similar to the other common sectors of employment, such as those professions covered by regular labour agreements. The NCDW states that domestic workers are entitled to negotiate hourly or monthly pay individually, without prejudice to a minimum contractual pay, whose values are re-valued annually by a national commission[38]. Moreover, domestic workers gain the right to a 4 percent increase in the minimum contractual pay every two years, and up to a maximum of seven times, in case they provide services for the same employer. Additionally, in the case of non-national citizens, the legal contract ensures the right to have access to social and health services under the same conditions as national workers.

In summary, Denmark and the Netherlands are characterised by stringent regulation of unqualified (domestic) workers. The migration policies of these countries make it hard for migrant domestic care workers from third countries to obtain a work permit[39]. Although the Hungarian and Croatian employment regime for in-home care is characterised by 'legalised informality', because of the limited requirements of the working regulation, the vast majority of care work remains informal and is organised *within* the family. Consequently, the legal regulation of domestic work does not guarantee non-national workers proper protection in terms of citizenship rights concerning social security. Even though domestic workers in Israel can benefit from almost all articles of the protective employment legislation guaranteed to Israeli citizens, the specific regulation for domestic work – guest (care) workers can be employed *only* as domestic carers – limits the possibility of integration of these workers into the Israeli society. Contrary to the other selected countries, in Italy and Spain domestic care is recognised by formal employment contracts. In these countries, the formal employment as an in-home worker is recognised as a route for non-national citizens to be granted employment rights. On the other hand, these working regulations require families to pay social contributions. Subsequently, due to the high costs for families hiring in-home workers, in these countries the irregularity in the domestic care

[38] In 2013, the minimal – that usually represent the average – salary of in-live care workers ranged from 950.25 Euro in the case of unqualified care workers, to 1173.83 Euro for a qualified care workers.

[39] According to OECD (2008) the share of employment of foreign-born in households in the Netherlands is non-existing, while in Denmark, with the exception of seasonal workers within agriculture who sometimes live in the family's household, hardly anyone works as live-in staff.

sector is a common and shared characteristic. When in-home workers are employed on an informal bases, the non-national care workers are nonetheless withhold from any form of recognition and protection.

4.5 Union representation

Among the countries involved in this study the occupational groups involved in the long-care sector are represented by a plurality of unions. Generally, these organisations tend to differ in terms of sectors of employment of the workers – private or public – and in terms of the occupations that are represented. In some countries, including Denmark and Hungary, the level of representation of domestic care workers is very limited. In these countries this occupation does not belong to the categories that are recognised by the main trade unions. Additionally, according to Szeman (2012), in Hungary the level of representation, and thus the advocacy of home care workers is weak. In Croatia, the 'Autonomous Trade Union in Health Service and Social Protection Service' represents all employees in health and social care regardless of their profession, qualification or education. There are no official unions specifically representing care workers. In the Netherlands, long-term care workers are represented by a multitude of organisations. These unions represent all employees in the nursing and care sector, including nurses, care assistants and home helps. In Spain, all the care work occupations, including domestic helpers and tele-assistance, are recognised and represented by trade unions operating in private or public sectors. In Italy, the principal Italian trade unions specifically represent care and domestic workers. Additionally, together with the associations of the employers these organisations have contributed to the process of developing and defining the current National Contract for Domestic Workers.

Across the selected countries, non-national domestic care workers are hardly represented by trade unions as a specific group with specific needs and interests. Overall, those unions that do recognise the (precarious) position of non-national domestic care workers, mainly provide services to non-national workers aimed at information provision. In Italy, the principal trade unions have set up a specific help desk for domestic workers ('Sportelli informativi Colf/Badanti') to provide information on contractual forms, on rules concerning the regularisation of labour relations and on the status of irregular workers. In the Netherlands, since 2006 Abvakabo FNV, one of the largest unions, has recognised migrant domestic workers – including undocumented migrants – as a specific category of workers requiring collective representation. The Abvakabo provides training programs or workshops on Dutch language, on employment rights, on the job and on unionism (Cremers, Bijleveld & Depuydt, 2008). In Croatia, the Association of Carers was founded in 2012 as an NGO dealing primarily with professional education and training. Moreover, they sought to employ its unemployed members in Croatia and abroad. In Israel, the 'Histadrut', the largest labour union in Israel, has decided to accept foreign workers to the organisation since 2010. The organisation's branch in Tel Aviv established a special department that

assists foreign workers to organise themselves, and to advocate and defend their rights[40]. In Spain, trade unions have so-called 'Secretaría de Igualdad' (Secretaries of Equality) which main task is to address the issues related to migrant workers. Additionally, there are several associations active in monitoring and promoting the migrant care workers' rights. One of the activities of these associations has been the 2010 demonstration of in-home workers in Madrid. Similarly in Italy, there are also specific associations of domestic/care workers that are particularly active in the promotion of the rights of migrant workers. The most important one is Acli Colf, an association that has been providing assistance and support to domestic workers for more than fifty years now. In Israel, there are several advocacy organisations addressing issues of policy, legislation, advocacy and day-to-day assistance for guest workers and their families. In Denmark, the FOA SOSU union offers a network for those members who wish to improve the integration process in the work place (Netværk I Fagbevægelsen (NIF SOSU)). A mentor is offered to immigrants who need help to finish their education as care workers at a Danish school.

To summarise, among the selected countries the principal function of the trade unions is to support the non-national care workers in providing them information about their employment rights in order to improve their working conditions. In addition, the unions, together with professional associations and/or NGOs, play a crucial role in raising awareness of the conditions of migrant workers among the public.

[40] Histadrut, the department for guest workers. http://www.histadrut.org.il/index.php?page_id=1251

5. SOCIAL RIGHTS: ENTITLEMENTS TO SOCIAL SECURITY BENEFITS

Whereas the previous chapter paid mainly attention to the *employment conditions* of migrants working in the formal residential sector and in the sector of domestic work, in this section we focus on the rights granted to migrant care workers to entitlements to *social security benefits*. By providing benefits to protect citizens against social risks including unemployment and sickness, social security systems constitute a powerful tool to reduce inequality and poverty and to promote social inclusion. Regulation (EC) 883/2004[41] on the Coordination of Social Security Systems and its implementing Regulation (EC) 987/2009 set the basic coordination principles regarding the application of social security schemes within the EU. These regulations do not replace or change the national social security systems in Member States, but rather protect a set of principles aimed at facilitating the free movement of EU citizens. It contains four main principles on social security: 1) equality of treatment and non-discrimination, 2) maintenance of acquired rights, 3) maintenance of rights in the course of acquisition, 4) transportability of benefits. Each country has its own rules for awarding benefits as all Member States are free to decide who has access to social security benefits and under what conditions. Social security refers to a wide range of benefits, each of which has its own eligibility criteria and distinct levels of generosity. In this paragraph we provide a brief overview of national social security systems and how they apply to migrant care workers from within the EU and migrant care workers from third countries (i.e. TCNs). TCNs concern a vulnerable group, since they tend to be concentrated in the lowest echelons of the LTC workforce, and tend to be confined in low-skilled and low-paid jobs with limited job security. Moreover, the issue of access to social security benefits is particularly pertinent to TCNs who may be exposed to the double risk of losing access to social security benefits in their country of origin through absence, while at the same time facing restrictions in entitlement to benefits in the destination country (European Commission, 2014).

The aim of this paragraph is to show that the social rights that both EU *and* non-EU migrant care workers can derive from their labour market position, is highly dependent on the social security system of the host country. Despite the shared commitment to improve the well-being of their populations through effective social security systems, the rules of Member States on who is entitled to social security, which benefits are granted to whom and under what conditions vary significantly across EU countries. In this report a distinction is made between the rights of care workers migrating from an EU country to another EU country and those migrating from non-EU countries to EU member states, i.e. TCNs. This section of the report is based on a synthesis report provided by the European Commission (2014) on the MISSOC[42]

[41] Denmark has not adopted the EU's legal Migration Directives and are therefore not bound by its provisions.

[42] The MISSOC national guides are developed in order to explain the rights that EU citizens who move from one Member State to another Member State enjoy resulting from Regulation (EC) no. 883/04 on the coordination of social security systems.

national guides. These guides are drafted in order to provide information to mobile EU nationals insured under national law. Yet, their categorisation of social security benefits – under eleven social security programmes[43] – provides a useful basis for analysing the variety of social security benefits that exist in each Member State to which both EU migrant care workers as well as TCN migrant care workers – who enter the host country on a work and/or residence permit – are entitled to.

The European Commission (2014) concludes that **long-term residents**[44] generally have access to all the benefits available across the eleven MISSOC programmes as long as they satisfy the general eligibility conditions that are attached to the benefits. Access to social security schemes is more restricted for **salaried workers** with temporary fixed-term residence permits. Overall, in most Member States salaried workers have access to sickness cash benefits as long as they fulfil the general eligibility conditions that apply to both TCNs and Member State nationals. Moreover, salaried workers are entitled to insurance-based maternity and paternity benefits, invalidity benefits, old-age benefits, survivors' benefits, and benefits in respect of accidents at work in countries studied in this report. However, in most EU Member States migrants with the status of salaried worker do not have access to family benefits, guaranteed minimum resources and long-term care benefits.

Even if TCNs are granted access to social security benefits, the eligibility rules attached to these benefits may directly or indirectly prevent TCNs from taking up the benefits in the seven MISSOC programmes considered in the selected countries. According to the European Commission (2014) these eligibility rules include the following:

- **Minimum residence period.** Evidence of legal residence – in the form of a valid residence permit – and evidence of the applicant's physical presence in the host country is a common eligibility condition for most social security benefits. A minimum residence period is usually however not required before TCNs can actually take-up the social benefits. In relation old-age benefits, Italy is an exception, where a residence period of 12 months it is required. In Hungary, Italy and Spain a minimum residence period is required to have access to the so-called guaranteed minimum resources.
- **Rules governing the export of benefits**. In most Member States the export of benefits to third-countries is restricted by national legislation of the host countries. This is the case for in-kind

The MISSOC data do not include Israel. For that reason, Israel is not discussed in this section of the report. The national guides are accessible through: http://ec.europa.eu/social/main.jsp?catId=858&langId=en

[43] (i)Healthcare (ii) Sickness cash benefits (iii) Maternity and paternity benefits (iv) Invalidity benefits (v) Old-age pensions and benefits (vi) Survivors' benefits (vii) Benefits in respect of accidents at work and occupational diseases (viii) Family benefits (ix) Unemployment benefits (x) Guaranteed minimum resources (xi) Long-term care benefits.

[44] Any third-country national who has long-term resident status as provided for under Articles 4 to 7 of Council Directive 2003/109/EC or as provided for under national legislation.

healthcare benefits in Denmark, Hungary, Italy, the Netherlands, Spain. In all selected countries except Hungary, the exportability of maternity and paternity benefits is restricted. Family benefits can also not be exported to the sending countries in the countries studied in this report. Unemployment benefits are not transportable either, as it is often required that the migrant resides in the host country. None of the countries included in this study allows for exporting benefits marked as guaranteed minimum resources. Hungary, the Netherlands and Spain allow TCNs to export old-age pensions to third-countries.

- **Minimum employment periods**. Of the selected countries only Hungary and Spain require a minimum period of contributions or employment (a so-called 'qualifying period'), before both TCNs and EU nationals can take up sickness cash benefits. In Hungary and Spain, the granting of access to maternity and paternity benefits is conditioned by a qualifying period of minimum accumulated contributions. Yet, this condition also applies to EU nationals. Only the Netherlands does not require a minimum employment or contribution period before TCNs have access to a state pension. In the other countries entitlement to old-age pension schemes is conditioned by a minimum period of employment or contribution. In all the selected countries a minimum employment period exists for TCNs to access the contributory unemployment benefits. These conditions also apply to EU nationals. Access to family benefits as well as guaranteed minimum resources, is usually not conditioned by a minimum period of employment.
- **Migration-specific conditions**. In all of the six EU countries, holding a valid residence permit is required to be entitled to most of the MISSOC social security programmes. In some instances, a long-term residence permit is required too. In the selected countries, no migration-specific conditions are attached to individual social security benefits. In some Member States, certain migration-specific conditions may apply to all social security benefits. An exception is Italy, requiring a valid work permit for 1 or 2 years (or less in case of seasonal workers) to be able to access unemployment benefits.

Overall, it can be concluded that in all the selected countries (Denmark, Hungary, Italy, the Netherlands, and Spain) TCNs are required to hold a valid residence permit in order to be entitled to social security schemes. Unlike many other EU Member States, the countries selected in this report do not require additional migrant-specific conditions for TCNs to have to access social security benefits. Nevertheless, EU Member States each regulate entitlements to social security benefits by local laws and country-specific eligibility criteria. Although these eligibility criteria apply to both TCN migrant care workers and EU nationals, these rules – that sometimes require a minimum period of residence, employment or contribution – may be a greater impediment for TCNs to access social security benefits because their presence in the host country tends to be more temporary (European Commission, 2014). Moreover, generally only those migrant care workers from third-countries who have obtained a work and/or non-temporary residence permit because they have (regular) employment contract, are entitled social

security benefits. This implies that migrant care workers who are not formally employed and thus not have a formal employment do not have the right to social benefits, including domestic workers with no, or an irregular, contract or those care workers informally employed in the so-called ‘grey market’. The opportunities for non-EU migrant care workers to get a work and/or residence permit are dependent on the migration policies of the host country. Therefore, the next section discusses the countries’ migration regimes.

6. Migration regime

The migration regime defines migrant care workers' possibilities in terms of labour market participation and position on the labour market, the possibility to naturalise and, ultimately, the accessibility of citizenship rights. In order to understand how these regimes affect the position and the citizenship status of the non-national care workers specific aspects have to be considered. The primary determinant of the migration process is the country of origin of non-national citizens, and the relationship between this country and the receiving country. Institutional migration agreements, as the case of free mobility of EU workers, favour the mobility of non-national citizens. At the same time, the entry, work and stay of migrant care workers can be obstructed by migration policies that are directed towards the attraction of highly-skilled profession, while migrants in the LTC sector often work in low-skilled lobs. In particular regulations regarding the granting of working and residence permits can be represent barriers that limit the possibility for migrant care workers to enter and work in a country. It also limits the possibility of migrant care workers to be recognised as a 'regular salaried workers', and thereby fostering the use of informal LTC arrangements.

6.1 Migration trajectory

6.1.1 Countries of origin

According to IMSERSO (2005) in Spain, the majority of migrant care workers come from Latin America, including Ecuador, Colombia, Peru and Dominican Republic. However, recently other nationalities have started to work in the Spanish LTC sector too, including workers from Argentina and Bolivia. Another important region of origin of non-national care workers in Spain is Eastern Europe, including Romania, Bulgaria, Poland and Ukraine. The Spanish LTC (informal) workforce also consists of workers from the Philippines. In Italy, Romania is the most important country of origin of registered care workers, followed by Ukraine, Moldova and Peru (INPS, 2013[45]). In 2011 around two-third of the regular migrant care workers in Italy had non-EU nationality, and their main countries of origin were Ukraine, Moldova, the Philippines, Peru, Sri Lanka and Ecuador. The most important countries of origin of EU migrant care workers were Romania and Poland. The last two countries represent the main important countries of origin for the limited share of non-national professional nurses too (Caritas Migrantes, 2012). In Israel, most of the migrant care workers come from the Philippines, Nepal, India, Sri Lanka, and Eastern Europe (Shamir, 2013). Recent data published by the Population and Immigration Authority indicate that in 2014 there were 42,878 legal labour care migrants (PIBA, 2014). A survey published in 2010 by the Ministry of Economy reported that approximately 48 percent of care workers were from the Philippines (Ben-Zuri, 2010). In Denmark, a study conducted in 2011 (*Omsorg og etnicitiet*; Care and Ethnicity,

[45] Data provided by National Social Security Service (INPS) online databases. Latest access on: 10/12/2014

2013) showed that the majority of migrant care workers come from countries of the Nordic European area. On the other side, second- or third generation migrants, so those who already live in Denmark and work in care sector, come from a wide array of countries. There is an almost equal share of people coming from the Middle East, Africa, and South-East Asia, while a minor portion is represented by EU citizens coming from Eastern Europeans countries, in particular from Poland (ibid.). In the Netherlands, there are no data available on the countries of origin of first generation migrant care workers who have migrated to the Netherlands for the purpose of work. However, there is information available on the overall composition of migrant workforce, including also second- and third generation migrants. The main non-native Dutch backgrounds in the formal LTC sector are Turkey, Morocco, Indonesia, Germany, and Surinam (OECD, 2014).

Before explaining the characteristics of the migration regime in Hungary and Croatia, it is important to clarify the countries' role in the European migration chain. Croatia and Hungary do not, unlike the previous countries discussed, represent popular *receiving countries* for migrants. According to the census data of 2010, in Hungary, only 143,197 persons (1.5 percent of the entire population), were non-Hungarian citizens. The Croatian Bureau of Statistics reports that, in 2013, only 0.53 percent non-Croatian citizens were working in Croatia. In Hungary, a considerable part of the migrant population consists of ethnic Hungarians coming from neighbouring Central Eastern European (CEE) countries whose mother tongue is Hungarian (Göncz et al., 2012). In relation to migrant care workers, the majority comes from Romania and there are also Hungarian immigrants from Ukraine employed by Hungarian families (Szeman & Turai, 2010; Szeman, 2012; Turai, 2013). In Croatia there is no record on how many migrants work in the care sector nor on their nationality. Jedvaj and Ježić (2013) argue that despite the limited need of foreign workers on the Croatian labour market in general, labour shortage and increased demand for non-national workers in the long-term care are expected in the future.

To summarise, in general the migration pattern of migrant care workers reflects the common migration route between higher- and lower-income countries. In particular, some countries tend to be characterised as common sending countries of migrant care workers, including the Philippines and Ukraine as non-EU sending countries, and Poland and Romania within the EU area. In relation to the latter case, it seems that the recent EU enlargement has fostered the migration of Eastern European countries' citizens within the EU area.

6.1.2 Relation between sending and receiving countries

Since the high level of emotional and relational features of the care work, one of the most important relations that link the sending countries and the receiving countries in the case of migrant care workers is shared and common culture and language between caregivers and care receivers. For example, although there are some cultural differences between Hungarians raised in Hungary and those raised

in other countries, language is not a barrier, since the ethnic Hungarian migrant care workers' mother tongue is often Hungarian too (Szeman & Turai, 2010). Thus, cultural links and shared language are an motivation for families to hire ethnic Hungarians. Similarly, in Denmark, the similar languages as well as similar educational systems between Denmark and the other Nordic countries, favour the integration and work of migrant care workers from Norway, Sweden and Finland in the Danish care sector. The absence of a lingual barrier could also be applied to the case of Latin America migrant care workers working in the Spanish care sector.

Another aspect that has shaped the migration patterns of migrant care workers is the recent enlargement of the EU with a number of Eastern European countries. The impact of the enlargement is clearly observable in Italy. In 2012, prior to the recognition of Romanian citizens' right to work in Italy the main area of origin of migrant care workers was South America, while after the full inclusion of Romania in the EU the majority of migrant care workers are citizens from Eastern European countries, especially Romanians (INPS, 2013). A similar trend was visible in Spain, where the transitional arrangements for Romanian workers was recognised in 2011. Both countries represent two important routes for Romanian migrant workers, and in a short period of time the Romanian population residing in these countries has increased up to around a million (OECD, 2014). In the Netherlands, migration is partly shaped by colonial history that result in inflows from Indonesia, Surinam, and the Netherlands Antilles, and also by its guest-worker programmes with Morocco and Turkey (Muus, 2004). Yet, the expansion of the EU towards the East has initiated migration flows from the countries of Central and Eastern Europe. Today, people of Polish origin make up by far the largest component in annual migration to the Netherlands, even when compared with non-Western migrant groups. Migrants from Romania and Bulgaria also account for a sizeable share of migrant workers to the Netherlands. However, these migrants are mainly employed in agriculture and the construction sector (OECD, 2014). In Israel there are no particular relationships between countries of origin of non-national care workers and Israel, except for the preferential access ensured to immigrants of Jewish origin. Approximately 14.4 percent of all Jews living in Israel in 1992 come from various parts of the former Soviet Union (Shamir, 2013).

6.2 Entry conditions for migrant care workers

In the six European countries involved in this study, EU citizens, in contrast to TNCs, enjoy free entry and residence rights, including free access to the labour market, and generally can be employed without a work or residence permit. Additionally, unemployment of EU nationals does not automatically preclude their possibility to continue their stay in the host country. Contrary, except in special circumstances, the stay of TCNs is conditioned upon having paid employment. For that reason this paragraph analyses the conditions that regulate the obtainment of a working and residence permit of the TNCs citizens.

Aside from the schemes for privileged access for highly-skilled workers – which can be applied only to professional nurses, and rarely concerns the non-qualified care workers – the guidelines that regulate the entry of TCNs workers, tend to respond to the principle of labour shortage in the care sector. In Denmark, foreigners who are employed in sectors with a lack of specialised labour have an easier access to a work and residence permits via the so-called 'Job Card Scheme' (Rostgaard, Chiatti & Lamura, 2011). Similar privileged access schemes characterise the migration regimes of almost all other countries, and generally apply only to the profession of qualified nurse. In contrast to the other countries, in Denmark and the Netherlands, these schemes – the entry of highly qualified workers – represent the principal way of entry for migrant care workers. The entry to Italy of non-EU workers for seasonal or non-seasonal work purposes is possible within the quota programmes. The aim of these quota is the temporary planning of the entry of non-EU workers to the national territory in accordance with possible labour market shortages. Similarly in Croatia, the rate of immigration of TCNs is restricted in advance by a system of work quotas that are regulated each year by the government and are limited to only a few professions. In Spain, labour migration flows are regulated in accordance with developments on the labour market. The employment of TCNs is regulated by the Catalogue of Occupations of Difficult Coverage that is set up annually by the Public State Employment Service. It contains a list of jobs that employers are allowed to fill by hiring foreign workers. In Israel, there are no administrative caps on the number of care workers that are allowed to enter in the country. Also, the share of non-national workers entitled to enter is attuned to possible shortages on the labour market. A migrant receives a visa to work in Israel in one of the sectors open for employment of foreign workers, including the provision of care to older people and disabled. In Croatia, the Netherlands, Hungary, Israel and Denmark, the employer has to demonstrate that they have been unable to find suitable personnel in the national workforce (or in the case of the Netherlands, in the national and EU workforce) in order to obtain the work permit for a non-EU migrant (care) worker

Generally, in order to be granted a working permit TCNs must have either a regular contract with their future employer or a binding document that certifies the future working relation. Additionally, any non-EU citizen seeking a working and residence permit in the selected EU countries has to demonstrate they have sufficient income level to maintain themselves during their stay, and need to have adequate housing arrangements in order to not become a burden on the national welfare systems.

In the EU countries that are studied in this report, the duration of the residence permit of TCNs matches that of the work permit, and its validity is generally granted for one year, or in the case of a permanent

work two or three years[46]. In Denmark and the Netherlands the procedure to obtain and extend the working permit is the responsibility of the employer, whereas in other countries this is a task of the migrant worker. In both cases, in order to obtain an extension of the working permit, TCNs have to fulfil the same criteria that regulate the attainment of such a permit: a working contract, financial sustainability and adequate housing arrangements. A work interruption does not coincide directly with the revoke of the residence permit, because it is generally granted for the entire duration of the work permit. Spanish regulations provide also a geographical restriction. In this country the initial authorisation of the residence permit is limited to a geographical area no greater than one autonomous community (art. 37.2 LO 4/2000)[47]. On the other hand, *after* the first concession authorisations are be granted without a geographical or occupational limitation (art. 38.7 LO 4/2000).

These requirements presented in the previous paragraph do not concern non-EU workers who are entitled of status of residence of long duration in the EU (Directive 2003/109/EC). In the case of long-term residency, the same working regulations applies to national citizens and TCNs alike.

The Israeli migration regime represents a special case. Labour migration policies in Israel are more similar to laws and regulations in the Gulf States and Southeast Asia than to those in Europe. Israel's policy is stricter than in countries with longer histories of foreign labour recruitment, and it takes measures to ensure that labour migrants stay only temporary[48] (Elias & Kemp, 2010; Shamir, 2013). To this end, migrant guest workers, like tourists and volunteers, receive a working visa for a limited period of time. Additionally, according to the Law of Entrance to Israel that was introduced in 2011 by the Israeli Parliament (Knesset), the Ministry of Interior restricts the number of employers that are allowed to employ care workers, as well as the limiting the geographical area in which care workers can be employed. According to this amendment, the Ministry of Interior can cancel a care worker's visa if the worker is unemployed for more than 90 days. However, the law also indicates that the circumstances under which a care worker decides to terminate her/his work with the employer must be considered. This aspect allows workers to preserve their right of freedom, and avoids the obligation to work for a

[46] In Hungary, due to difficulty to obtain a working permit for TCNs, together with the high level of informality of working regulation of care worker, the majority of Ukrainian care workers usually apply for tourist visa with the invitation from the employers that expires within three months, and Hungarian families sometimes hire two migrant care workers, each of them for three months, thus, the care workers alternates (Szeman, 2012).

[47] These limitations are not applied to the citizens of countries to which Spain has signed agreements on the regulation of migratory flows (art. 39.3 LO 4/2000). Currently, these countries are Ukraine, Mauritania, the Dominican Republic, Morocco, Ecuador, and Colombia.

[48] The visa itself is usually valid for 30 days only. The immigrants have to go to the local MOI office and extend it on a yearly basis. A work visa usually enables to live in Israel for up to five years (Elias & Kemp, 2010; Shamir, 2013).

certain employer.[49] Furthermore, there are strict family-related migration policies for migrant guest workers aimed at discouraging family formation or family re-unification. For example, a person will only receive a permit to enter if they do not have a close family member in the country. Moreover, if two migrant workers get married in Israel, one is required to leave. Additionally, until recently, a female migrant worker who gave birth, had to leave the country with her new-born within 12 weeks[50] (Shamir, 2013; Elias & Kemp, 2010).

It can be concluded that the entry *requirements* for migrant care workers depend on their citizenship status (i.e. EU citizen versus non-EU citizen) and their position on the labour market (formal employment versus informal employment). Whereas EU nationals do not require a work or residence permit to work in another EU country, non-EU nationals (i.e. TCNs) need at least a residence or work permit to be employed in the formal LTC sector. However, TCNs can also enter a country without the specific purpose to work in the LTC sector, and thus without a working and residence permit. As noted by Cangiano et al. (2009), the care sector is generally considered as a market that is 'easy to enter' and migrants can sometimes enter the country with a temporary (student or tourist) visa and then work in the informal LTC sector. With regard to the examined countries, this is the case in Hungary and Italy. In Hungary migrant care workers from neighbouring countries (e.g. Ukraine) enter the country via a temporary tourist visa of three months. After this period the migrant care workers come back to the country of origin in order to obtain a new tourist visa. In Italy the regularisation of migrant care workers that occurred in 2009 and 2012, has led to the regularisation of the broad part of migrant care workers who already resided and worked in the country without a working or residence permit (employment mainly in the grey market).

Although EU nationals can freely cross the EU borders and work in another EU Member State, being able to work in the LTC sector obviously depends on the availability of jobs in this sector too and on having the required educational qualifications. While TCNs are also dependent on the employment opportunities in LTC in the host countries, the possibilities they have to obtain a work or residence permit are also dependent on their professional status. TCN workers in LTC that are higher on the professional ladder, i.e. the higher-skilled professions including nurses, tend to have privileged access.

[49] Association for Civil Rights in Israel http://www.acri.org.il/en/, and All Rights Association http://www.kolzchut.org.il/en/Main_Page

[50] There are exceptions within this line of policy: During June 2005, the government decided to grant permanent residency and later citizenship to children of labour migrants aged ten and over who were born in Israel, speak Hebrew, and are currently studying or have completed their studies in Israel. The status of the children grants their parents and younger siblings a yearly renewable status as temporary residents, entitling them full social rights. Furthermore, once enlisted in the Israeli army (a requirement of all 18 year olds), these children and their siblings will become Israeli citizens and their parents will be granted permanent residency (Elias & Kemp, 2010).

However, in those countries in which migrant care work is most prevalent, migrants are mainly employed in the informal sector performing low-skilled work. Furthermore, the rights for TCNs to reside and settle in the host country are often circumscribed by the need to proof economic independence. So, a common migration trajectory for migrant care workers – i.e. entering the host country to perform low-skilled jobs in the informal LTC sector – provides them with limited opportunities to obtain a non-temporary residence permit or work permit. Migrant care workers who stay in the host country on a temporary residence permit or on a tourist visa, are unlikely to satisfy the condition regarding sufficient financial resources that is generally required for a long-term residence permit. Moreover, the absence of a so-called sponsor (an employer) makes it hard to obtain a work permit.

6.3 Residence and naturalisation conditions

In the EU countries considered in this report, the residence, settlement and naturalisation of foreign citizens is not tied to a particular form of employment, profession or sector of employment. However, a requirement for the obtainment of a residence permit, and thus of the possible subsequent naturalisation, is the possession of *long-term, sufficient and independent means of subsistence*. A stable or regular income is a requirement for long-term residence status of TCNs under EU Council Directive 2003/109/EC. Exempted from the requirements are only the nationals of the EU, EEA and Switzerland. For a migrant care worker the means of subsistence are considered 'independent' if they originate form wage from employment. The income is considered 'long-term' and 'sustainable' if it is available for at least a year after the application for a (provisional) residence permit is submitted and/ or a decision regarding the entry or residence is issued. The exact amount required ('sufficient') varies across countries, but generally it is a legally prescribed income level in order to avoid that migrant care workers become a 'burden' for the national social assistance systems[51].

In all EU countries analysed in this report, after continuous residence non-EU citizens are entitled to a residence permit of long duration in the EU. This permit authorises foreign citizens to work and reside in the EU countries under the same conditions as national citizens. In Netherlands, five years of uninterrupted rightful residence is the criteria that regulates the obtaining Dutch citizenship via naturalisation. In Italy and Spain this criteria is set at 10 years. However, in the case of EU citizens and citizens from former colonies (covering several countries in Latin American and the Philippines) that have a migration agreement with Spain, the required period of uninterrupted residence is reduced, to 4 and 2 years respectively. In 2010 the Hungarian government amended the Citizenship Act of 1993

[51] For example, in Spain the migrant care workers' monthly salary must be at least equal to the national monthly minimum full time wage. In Italy, the requirement is set on an annual base, and the migrant care worker' income has to be higher than the threshold established for the benefit of the minimum-income benefit (assegno sociale). In the Netherlands, the financial requisite depends on the situation of the migrant care workers and / or sponsor and ranges from 70 percent to 100 percent of the legal minimum wage.

enabling a shorter and simpler naturalisation process for ethnic Hungarians who are able to prove their Hungarian origin and who speak the Hungarian language fluently. Otherwise, naturalisation is only possible if the applicant has been living in Hungary permanently over the last eight years, speaks fluently Hungarian and passes an exam about the constitution. Similarly in the Netherlands, in principle all future citizens need to prove their integration in the Dutch society either by passing a civic integration examination and/or by demonstrating their knowledge of the Dutch language by means of their diplomas and certificates. In Denmark, future citizens have to demonstrate, beside fluency in Danish, their knowledge of Danish society, politics and history. The minimum period of uninterrupted residence necessary for obtain a naturalisation is nine years.

Also in the process of naturalisation Israel, as a non-EU country, appears to be a deviant case. Immigration policies in Israel limit the ability of foreign workers to become a resident or citizen of Israel. Obtaining the Israeli nationality is limited to Jewish people only. In general, immigration policies in Israel are primarily based on the implementation of the principles of *ius sanguinis*. In practice, this ancestry-based entry principle restricts citizenship to immigrants of Jewish origin. This immigration policy stems from the basic tenets of Zionism, according to which Israel is the homeland of the Jewish people, and immigration is perceived as 'home coming' rather than foreigners seeking to settle in another country (Gal, 2008; Elias & Kemp, 2010). In Israel the 1950 Law of Return gives the right to citizenship on arrival to every Jew who comes to Israel, with no conditions of length of residency or language proficiency. This is not only a statutory right "but a 'natural' right of every Jew in the world that precedes and constitutes the state" (Joppke & Rosenhek, 2002, cited in Gal & Halevy, 2014).

Table 6.1 Migration regimes for EU citizens versus TCNs

Citizenship status	**Employment conditions**	**Conditions for non-temporary residence permit**
EU citizens	Formal employment: ▪ Availability of jobs, and ▪ having the required qualifications	▪ n.a.
EU citizens	Informal employment: ▪ Availability of jobs	
Third Country Nationals (TCNs)	Formal employment: ▪ Having a **work permit**; privileged access for highly-skilled workers, or ▪ having a **non-temporary residence permit**, and ▪ availability of jobs, and ▪ having the required qualifications	▪ Possession of *long-term, sufficient and independent means of subsistence*
Third Country Nationals (TCNs)	Legal informal employment: ▪ Having a **tourist** or **student visa**, or ▪ having a **temporary residence permit**, or ▪ having a **non-temporary residence permit** and ▪ availability of jobs	
Third Country Nationals (TCNs)	Illegal informal employment: ▪ Availability of jobs	

Although the migration regimes obviously vary across countries, Table 6.1 provides a general overview of how an individual's citizenship status affects their employment opportunities in the formal and informal sector. Furthermore, Table 6.1 shows under what conditions – in general – EU nationals and TCNs can obtain a non-temporary residence permit. In the EU countries the processes of obtaining residence and naturalisation for TCNs are related to their employment status and the level of financial independence, which are obviously related. In the case of EU citizens' residence authorisation can be easily obtained based on EU immigration agreements. But also in this case, foreign (EU) citizens have to prove to not become a burden on the national welfare state system. In relation to migrant care workers, both residence and naturalisation can be particularly relevant in those countries in which the employment of non-national care workers is regulated by formal working contract and for a long-term duration. Contrary, in countries in which the care and employment regime foster the hiring of migrant care workers in low-paid and unqualified jobs, characterised by a high level of informality and/or temporary working contracts, the possibility for non-national care workers (both EU and non-EU) to settle in the destination country is hampered. In Israel, even more barriers exist for migrant care workers to enter the country, because migrant workers, regardless of their country of origin, profession or qualifications are considered to be temporary guest workers unless they are Jewish.

DISCUSSION AND CONCLUSIONS

The aim of this report is threefold. First, to understand how patterns of migrant work in long-term care[52] in six[53] EU member states and Israel are contingent on national care, employment and migration policies. Second, to understand the implications of the reliance on, and prevalence of, migrant care work for the citizenship rights that can be exercised by migrant workers in LTC. Third, by studying the phenomenon of migrant care work we seek to gain insight in the extent to which the right to receive professional long-term care is considered an integral part of citizenship and, implicitly, the extent to which migrant care work is recognised as a socially and economically valuable activity.

In this concluding section we present a framework for understanding distinct patterns of migrant care work (*first aim and second aim*), based on the analysis of the care, employment and migration regimes of the countries studied in this report: Croatia, Denmark, Hungary, Israel, Italy, the Netherlands and Spain. In the second part of this section, we explain how patterns of migrants care work are related to citizens' right to receive care (*third aim*). In this final part, we explain why exploring the intersection of care, employment and migration regimes is not sufficient in order to comprehend the accessibility of social rights for migrant care workers. It is argued that the role of host countries' social security systems must be considered too.

UNDERSTANDING PATTERNS OF MIGRANT CARE WORK

Based on our analysis of the countries' care, employment and migration regimes and their reliance on migrant care work, we introduce a theoretical ideal-typical categorisation of how the intersection of regimes explains patterns of migrant care work across countries (see Table 7.1). This sets a path for discussion on how welfare states – intendedly or unintendedly – shape the trajectories of migrant care workers because of country-specific social policies on care, employment and migration. We will now describe each of the 'migrant care worker models' in an ideal-typical[54] way "so that they will serve as rational structures against the rational/irrational empirical world" (Knijn & Verhagen, 2007: 460).

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[52] Long-term care is defined "as care for people needing assistance with various activities of daily living (ADL) over a prolonged period of time. A broad definition includes not only personal care such as bathing, dressing, and eating, but also additional tasks in which older and disabled people might not be self-sufficient (e.g., shopping, preparing meals, housekeeping)" (Cangiano, 2014: 150).

[53] Croatia, Denmark, Hungary, Italy, Spain and the Netherlands.

[54] We will follow Weber's (1904/1971) definition of an ideal type: "An ideal type is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent concrete individual phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified analytical construct (Gedankenbild)" (p. 63).

Type 1: State-supported professional MCW[55] model

In the 'state-supported professional MCW model', reliance on migrant care work is limited. *If* migrant care workers are present in this MCW model, it concerns EU nationals who are employed as salaried professional workers in the formal LTC sector. This can be explained by the combination of care, employment and migration policies. The care system reflects a combination of a state and professional logic, as LTC is considered a public good that must be provided by trained and qualified professionals, who guarantee good quality care. Cash-benefits schemes exist and are moderately generous in terms of funding. However, control on the way cash-benefits are spend by care receivers is strict and tied to conditions on who is allowed to provide the LTC services. Cash-benefits schemes are first and foremost aimed at improving client's choice. In this model citizens have a right to receive professional LTC services, and the care system is characterised by high levels of public funding. This is subsequently reflected in the country's employment regime, where LTC is recognised as professional wage labour that should, ideally, not be provided by unqualified caregivers, including family members or lay persons.

The national LTC workforce consists mainly of qualified professional salaried workers who are employed in the formal (residential or home care) sector. The employment of TCNs in the formal sector is conditioned by the need to have a valid work permit. The working conditions for care workers in the formal and informal sector are regulated by law. Because LTC is predominantly provided by professional care workers, the interests of these qualified workers are well-represented by trade unions. In terms of migration policies, all three MCW models have more or less similar requirements on length of residence and economic independence of TCNs in order to naturalise and to become full citizens of the host country. The dominance of formal care provision by qualified professionals is reflected in the entry rules for migrant care workers from third-countries. Migration policies aim at selectivity and targeted restriction, which means that only highly-skilled professionals have privileged access to obtain a work permit. For that reason, migrant care workers mainly consist of EU citizens. Countries that represent the 'state-supported professional MCW model' are Denmark and the Netherlands.

[55] Migrant care worker

Type 2: State-supported domestic MCW model

In the 'state-supported domestic MCW model' reliance on migrant care workers is strong. Migrant care workers come from both EU countries as well as from non-EU countries (often migrants from former colonies) and are either formally or informally employed as domestic care workers. The organisation of the care system is based on the state and family logic of care. LTC is not considered as wage labour that must be provided by qualified workers. Instead, LTC service provision by family members, laypersons or other non-professional caregivers is stimulated through cash-benefits schemes. Although the existence of uncontrolled generous cash-benefits schemes seem to reflect citizens' right to receive care, the state seems to encourage the hiring of *non-professional* caregivers. These LTC systems that are (partly) rest on the family of care, may be characterised by a large underground economy, which may represent a favourable condition for the family-based patterns of care provision and/or (illegal) informal employment of migrant care workers.

The size of the formal LTC sector, and the residential care sector in particular, is small and the national workforce is mainly employed in the home care sector. Compared to the 'state-supported professional MCW model' the level of professionalisation of the LTC sector is relatively low. Only the working conditions in the formal (domestic) care sector are regulated by law. The working conditions of those employed irregularly in private households are defined by the informal caregiver-care receiver relationship. In contrast to the 'state-supported professional MCW model', in the 'state-supported domestic MCW model', less restrictions are imposed on the possibility for TCNs to obtain work permits to be employed as domestic care workers. Specific regulations exist for (unqualified) migrants from third-countries to enter the country to work as a domestic care worker in times of shortages on the LTC labour market. Migrant care workers sometimes enter the country on tourist visa. The existence of generous and uncontrolled cash-benefits schemes stimulate the employment of (unqualified) migrant domestic care workers. Probably due to the strong reliance on domestic migrant care workers, unions recognise the (precarious) position of non-national domestic care workers. Compared to the two other MCW models, (non-national) domestic care workers in the 'state-supported domestic MCW model' are collectively well-represented by advocacy organisations and trade unions. Spain and Italy exemplify this type of MCW model.

Type 3: Institutionalised-informality MCW model

In the 'legalised-informality MCW model' the family logic prevails in the LTC system. LTC is not recognised as professional wage labour, as the majority of the LTC is arranged within households by family members**.** LTC services are (mainly) funded privately, or offered unpaid, and are provided in the informal sphere by non-professional workers, including family-members or friends. Citizens cannot claim to receive affordable and adequate LTC services as it is largely subjective to the informal caregiver-care receiver relationship. Citizens' right to receive LTC is restricted, as the formal and

professional LTC sector is underdeveloped while at the same time cash-benefits schemes have tied eligibility criteria and/or have a residual character. Even though such a system may represent a favourable condition for employment of (live-in) migrant care workers, reliance on migrant care work is very limited. This can be partly explained by the role of cash-benefits. Whereas the generous and uncontrolled cash-benefits schemes of the 'state-supported domestic MCW model' provide those in need of care with the opportunity to hire (non)professional caregivers themselves, citizens in the 'institutionalised-informality MCW model' neither have the right to professional nor to non-professional LTC services. Because the vast majority of care work is arranged informally and is organised *within* the family, there are relatively few regulations on the working conditions for domestic care workers. Like the 'state-supported professional MCW model', countries belonging to the 'institutionalised-informality MCW model' migration policies are characterised by selectivity. However, unlike the 'state-supported domestic MCW model', no attempts are made to encourage the hiring of non-national care workers. The collective representation of (migrant) care workers in trade unions is weak. Croatia and Hungary are more or less representative for this type of MCW model[56].

Israel: a deviant case

Even though Israel has different characteristics than the Southern EU countries analysed in this report, in Israel the intersection of care, employment and migration regimes, also foster the employment of migrant care workers in the domestic sector. Unlike the Southern European countries, cash-benefits schemes are absent in Israel. Instead, public subsidies are provided to private agencies that provide services mainly through guest care workers who are entitled to stay in the country only for a limited period and under strict conditions. Compared to Italy and Spain, working conditions in Israel are more regulated due to the formal character of LTC services, but like in the Southern European countries, the working conditions of non-national care workers are precarious. In Israel, LTC is considered as a low-paid unqualified work that should be provided by commercial organisations. The trade unions and NGOs play an important role in raising awareness on the vulnerable position of guest care workers that result from the strict migration regime, characterised by policies that hamper family formation of non-national citizens.

[56] To some extent Israel exemplifies this MCW model too. However, unlike Hungary and Croatia, the reliance on migrant care workers is actually strong in Israel. And unlike the other countries studied, the role of the market is more dominant.

Table 7.1 Understanding patterns of migrant care work

	Type 1: State-supported professional MCW model	**Type 2: State-supported domestic MCW model**	**Type 3: Institutionalised-informality MCW model**
Care regime			
Logic of care	State/professional	State/family	Family
Right to receive care	Right to receive prof. LTC	Right to receive LTC	Restricted right to receive LTC
Level of professio-nalisation LTC	High	Low	Low
Funding of LTC	Public	Public/private	Public/private
Cash-benefits schemes	Moderately generous in funding; strict control	Generous; uncontrolled	Residual funding and eligibility criteria
Employment regime			
Recognition LTC	LTC recognised as professional wage labour	LTC *not* recognised as professional wage labour	LTC *not* recognised as professional wage labour
National LTC workforce	Residential and home care sector	Home care sector	Residential and home care sector
Employment procedures TCN MCWs	Minimum requirements: formal sector: valid work and/or residence permit informal sector: temporary visa	Minimum requirements: formal sector: valid work and/or residence permit informal sector: temporary visa	Minimum requirements: formal sector: valid work and/or residence permit informal sector: temporary visa
Regulation care work	Working conditions regulated in formal and informal sector	Working conditions only regulated in case of formal employment	Working conditions unregulated
Union representation (M)CW	Professional workers well-represented	Specific unions for domestic care workers	(Migrant) care workers weakly organised
Migration regime			
Policies on entry MCWs from third-countries	Selectivity and targeted restriction; privileged access for highly-skilled professional MCWs to obtain work permit	Preferential access domestic MCWs; access to work permits depends on demand for MCW	Barriers to entry for MCWs; restrictions imposed on access to work permits
Requirements residence permit	Economic independence	Economic independence	Economic independence
Rules for naturalisation	Residency requirements; economic independence	Residency requirements; economic independence	Residency requirements; economic independence
Entry routes MCWs	Family reunification; intra-EU mobility	Intra-EU mobility; employment	Sending rather than receiving country
Migrant care work			
Reliance on MCW	Limited	Strong	Very limited
Employment MCWs	Formal LTC	Formal/informal LTC	Informal LTC
Country of origin	EU	EU/non-EU (former colonies)	EU

THE RELATION BETWEEN THE 'RIGHT TO RECEIVE CARE' AND MIGRANT CARE WORK

The different 'migrant care worker models' actually demonstrate under which conditions distinct patterns of migrant care work prevail. It can be concluded that there seems to be a close relationship between citizens' right to receive LTC services and the way migrant care work is manifest in a country. In countries where citizens have *the right to receive professional LTC services*, a well-developed formal LTC system exists in which care is provided by trained professional workers. This is reflected in migration policies too, where access is restricted for unqualified workers from third-countries and where highly-skilled workers have privileged access. Consequently, considerable barriers exist for low-skilled, unqualified migrants to obtain a work permit.

The employment of (unqualified) migrant care workers seems to be fostered in those countries where the family logic of care prevails and where citizens have *the right to receive non-professional LTC*. LTC systems in which care tends to be provided in the informal sphere by non-professional workers, may be characterised by a large underground economy, which may represent a favourable condition for the informal employment of migrant care workers as live-in workers. And when the state supports care provision within the private household through the entitlement to cash-benefits schemes, the hiring of non-professional migrant care givers is facilitated. Furthermore, the absence of a well-developed professional LTC system seems to imply that less restrictions are imposed on the educational requirements for TCNs migrant care workers, which also facilitates entry for low-skilled migrant care workers. In countries where the family logic is dominant, but where the state does not recognise citizens' right to receive (non-professional) LTC by offering cash benefits, care receivers seem to be less likely to hire a migrant care worker.

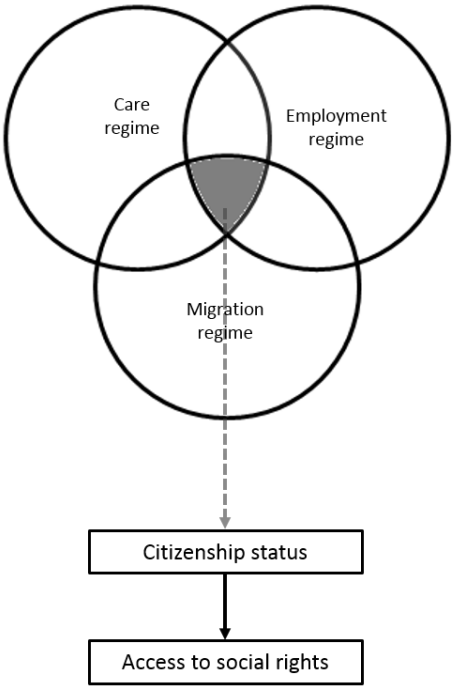
ACCESS TO CITIZENSHIP RIGHTS DEPENDS ON LABOUR-MARKET POSITION AND RESIDENCE STATUS

This report shows that analysing a country's care, employment and migration policies helps to improve our understanding of the distinct patterns of migrant care work. Additionally the report highlights that when the care, employment and migration triangle is applied and integrated in the analysis of the eligibility rules attached to the social security benefits of host countries, it becomes a powerful theoretical framework for understanding the social citizenship rights that EU nationals as well as TCNs are entitled to in a particular country.

Figure 7.1 illustrates how the intersection of the care, employment and migration regimes define the citizenship status of migration care worker, i.e. the legal status of a migrant in the host country. Generally, EU nationals and non-EU national (i.e. TCNs) with a permanent residence permit or work permit in combination with a permanent residence permit are subject to the same eligibility criteria in order to have access to social security benefits. Migrant care workers who do not have a valid work permit, or who only have a temporary residence permit have in some cases no, or restricted access, to

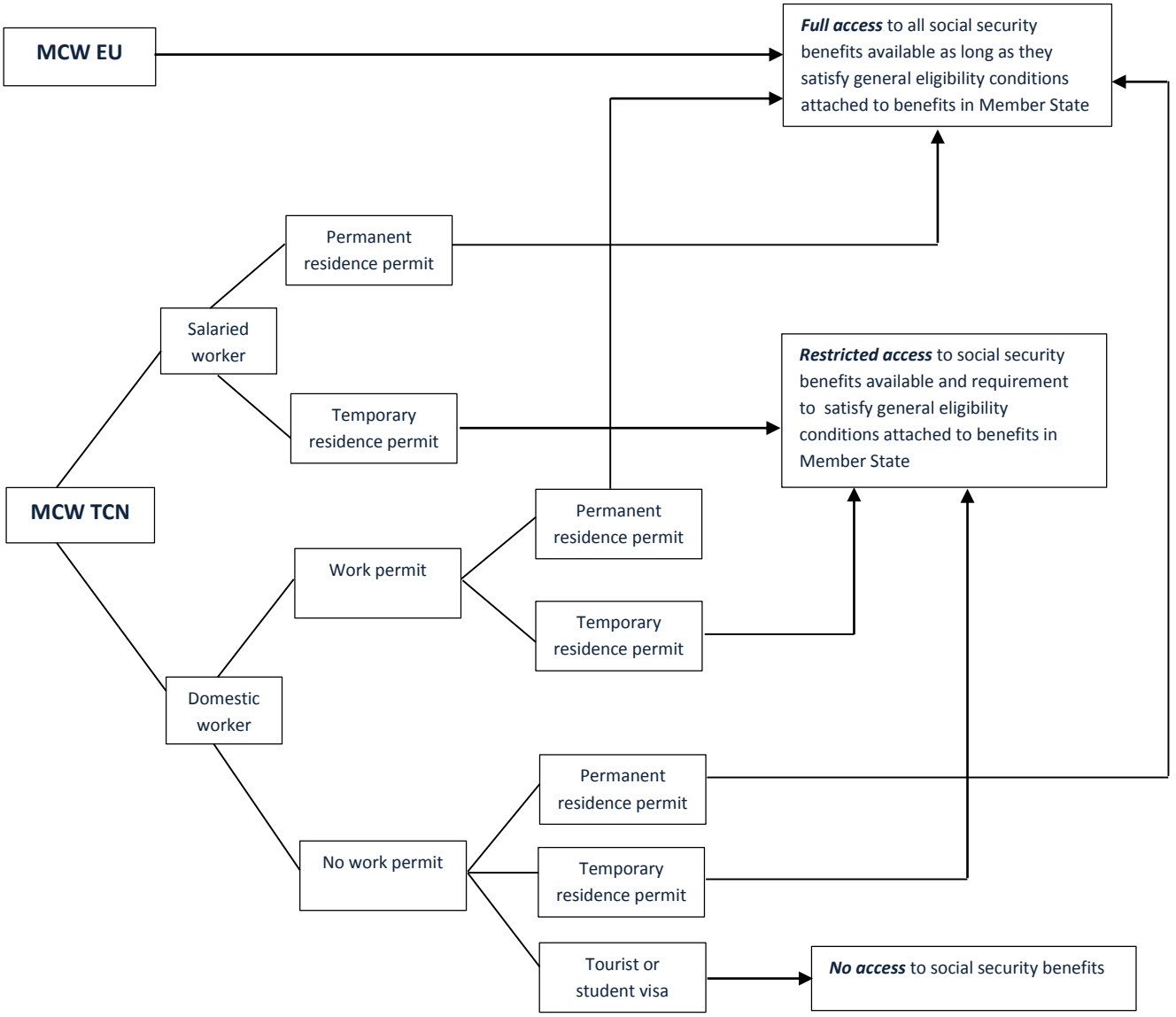
social security schemes. This is the case for live-in workers who have an informal and irregular employment status, and who have a temporary residence status (see Figure 7.2). So, while most eligibility criteria to have access to social security systems apply to EU nationals and third-country national applicants alike, they often represent a greater hurdle for TCN migrant care workers. This is also because TCNs, predominantly those being low-skilled and unqualified, have more limited access to the labour market vis-à-vis EU nationals.

Figure 7.1 Access to citizenship rights for migrant care workers



In general, it can be concluded that the type of work and/or residence permit a migrant care worker holds is key to understanding their access to social security benefits. Migrant care workers – except those entering the host country on a 'highly-skilled worker' status – are in a vulnerable position due to the (often) temporary character and/or irregular nature of their employment status, which makes it hard to gain financial independence. Migrant care workers' attainment of citizenship rights is therefore circumscribed by their position in the labour market (cf. Erel, 2012). For migrant care workers, the way to receive social citizenship rights is narrowed down to being financially independent (Knijn & Kremer, 1997), making regular paid employment in the key to social citizenship.

Figure 7.2 Flowchart access to social security benefits



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ANNEXES

APPENDIX 1: EDUCATIONAL QUALIFICATIONS FOR CARING PROFESSIONS

	Nurses	Care workers	Care assistants	Live-in carers
DENMARK	university degree (3 years)	1 year and 8 months of training , plus the social and health service helper education (1 year and 2 months)	1 year and 2 months, whereof 8 months consists of traineeships, plus a 20 weeks basic course in social and health service	professionals not required and recognised
THE NETHERLADS	higher professional education (four years)	(care assistant in individual health care) three-year training programme (vocational training level 3)	level 1 or 2 (vocational) training programme, respectively: one year of training, and two years full-time assistant vocational education	professionals not required and recognised
SPAIN	university degree (4 years)	title of vocational training secondary studies	certificate of professionalism	certificate of professionalism
ITALY	university degree (3 years)	health and social care operator (OSS): Regional Authorities have the competence to organise specific vocational training nationally recognised		no qualification or vocational training required
ISRAEL	academic and qualified nurses: four years training practical nurses: one year training	short course prior to placement at work, or alternatively on-the-job training. The Ministry of Health requires institutions to provide training, and recommends a 120 hours programme		no qualification or vocational training required
HUNGARY	associate degree (majority), or college degree (minority)	the institutional: associate degree; home care sector: no qualification or vocational training required		no qualification or vocational training required
CROATIA	professional medical high school as a basic training, and a higher education study program for a chief nurse	at least a high school diploma, and diploma from an officially recognized study program for the profession of care-worker	(care assistants for persons with disability) no specific training required	no qualification or vocational training required