Family Issue or Professional Responsibility?

Live-in migrant care arrangements and social discourses about legitimate elder care in the Netherlands

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Abstract
The deep reform that the Dutch long-term care system is undergoing has led observers to expect the rise and growth of a private market of live-in migrant care workers. According to these observers, the deinstitutionalization and informalization of the long-term care system would likely foster the creation of a market of home care services, including live-in migrant care (LIMC) arrangements. However, in spite of the emergence of a small market of providers of live-in migrant carers since 2012, this sector is not growing over the years. How can we explain this limited success of LIMC arrangements in the Netherlands? Based on the analysis of 46 internet discussions and four focus groups with family carers, this article sets out to explore the social arguments against and in favor of employing live-in migrant care arrangements. Our findings show a relative inconsistency between the social discourses of the wider public (in internet fora) and the opinions of family carers (in focus groups). In internet discussions a negative attitude towards the employment of live-in migrant carers prevails, based on four main arguments (non-affordability, labor displacement of native professionals, exploitation of migrant carers, and communication problems). On the other hand, our focus groups with family carers of elderly people living at home who do not employ live-in care workers, show that they do not choose for LIMC due to opportunity (availability of state-funded care services) and care ideals (most participants prefer professional care in combination with family care). Participants’ perceptions of LIMC arrangements do not match either ideals of professional care or family duty towards their relatives.

Key words
live-in migrant carers, family carers, social discourses, care ideals, informalization of care, professionalization of care, LTC reform, family solidarity

1 The data for this paper were collected as part of a larger research project entitled ‘The Emergence and Significance of Transnational Care Arrangements (ESTRANCA)’. This project was financed by the Netherlands Organisation for Scientific Research (NWO) and the German Research Foundation (DFG) in the framework of the Open Research Area (ORA) programme. The project was a cooperation between the Gutenberg University Mainz and the Radboud University Nijmegen.
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1. Introduction

Since the last decades of the past century, migrant care workers are being hired in growing numbers to care for frail elderly living at home. This phenomenon, known as the ‘migrant in the family’ (Bettio et al. 2006), is widespread in many European countries including Italy, Spain, Austria or Germany. The demand for live-in migrant carers (LIMC) is assumed to be low in countries with high public expenditures on long-term care (LTC), a highly professionalized LTC sector, regulated cash-for-care benefits, and a limited underground economy (Bettio et al. 2006; Van Hooren 2012; Da Roit & Weicht 2013). The Netherlands have historically had a universalistic long-term care system, with a high level of public responsibility and a lower level of family responsibility (Mot et al. 2010; Böcker, Horn and Schweppe 2017), which leaves small room for the employment of live-in migrant care (LIMC) workers.

However, the profound process of reform that the Dutch system is undergoing in the last decades has made some scholars expect the development of a market of live-in migrant care workers (Kiwi Carity 2013, Da Roit & Van Bochove 2014: 7-8, Da Roit & Van Bochove 2015). The reduction of the role of the state and the stimulation of the supply of informal care opened the way for the emergence of LIMC arrangements. The current policy priority is to keep elderly living in their own home as long as possible. Accordingly, residential care has been restricted to those with severe care needs, and the network of care homes targeting elderly with higher levels of autonomy has been partly dismantled. Within the new policy frame of the ‘participation society’, older people are expected to remain living in their own home as long as possible, and to receive care and support by relatives and neighbors. In line with this, policymakers have launched measures to encourage families to actively engage in caregiving. A policy measure that facilitates ‘ageing in place’ arrangements are the cash benefits gradually introduced from 2008, which allow care recipients and their relatives to buy care services in the market.

Potentially, the decline of the role of the state can lead towards the informalization of LTC. However, changes in the family structure and in female activity rates hinders such refamilialization. Since the last decades of the 20th century, the raise in female participation in the Dutch labor market resulted in higher competing demands between employment and informal caregiving. Empirical studies support the hypothesis that informal care and employment do compete for caregivers’ time, particularly among middle-aged women (Scharlach & Boyd 1989). Primary caregivers of elders with greater care needs are more likely to take unpaid leave, reduce work hours, or rearrange their work schedules to assume care responsibilities (Stone & Short 1990). As caregiving is often very stressful and disruptive for the caregiver (Dunkin & Anderson-Hanley 1998, Haley 1997), family caregivers tend to apply problem-solving strategies at their hand. Studies indicate that family caregivers’ coping abilities can be associated to their relative use of formal care arrangements, particularly long-term public services such as home care and institutional care (McKee et al. 1997)\(^3\). However, recent policy reforms devolving substantial responsibilities to families, and more specifically, to women, put increased pressure on family carers. As growing numbers of elderly choose to

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\(^3\) McKee et al. (1997) study of coping strategies used by supporters of elderly with dementia found that the majority of caregivers reported coping well and used predominantly emotion-focused coping. McKee and colleagues acknowledge here a possible selection bias: “Perhaps this is a group of ‘hardy survivors’; supporters who cannot cope with an elderly relative may seek ways to disengage from the caregiving role, by allowing formal support services to take over the main burden of caring, or by seeking a residential placement for their elder” (1997: 335).
remain living at their own home, the care responsibilities of their relatives and other informal carers also expand.

In line with the crowding-out thesis (Künemund & Rein 1999, Kohli 1999), we can expect that family carers would be inclined to provide limited levels of caregiving, used as they are to a generous LTC system with high service level. Predominant Dutch care ideals show a preference for a ‘warm-modern care model’ that combines professional care and family care (Van den Broek 2016), which merges beliefs such as the state’s care responsibility (Deeming and Keen 2003) or the generalized expectation that children should support their older parents (Dykstra & Fokkema 2012, Gans & Silverstein 2006).

All of this suggests that attempts to informalize LTC policies can actually open the way for the emergence of a LIMC market. In this scenario, it is reasonable to expect that family carers of elderly people would resort increasingly to private care arrangements, most likely to LIMC ones given that they are more affordable. Particularly for family carers of frail elderly who prefer to live at home, the possibility to hire a live-in migrant carer appears to be a good alternative to both institutional care and family care. Such alternative care arrangements do not necessarily need to be seen as something fundamentally different or contradictory with basic Dutch care ideals. For example, as demonstrated by Weich (2010) in his research on the Austrian case, live-in migrant carers can be constructed in public opinion in a way that they sustain and reinforce the ideal of family care, instead of challenging it. In Austria live-in migrant carers are constructed as ‘fictive kin’ (Mac Rae 1992), and therefore perceived as a ‘family surrogate’ (Weich 2010).

From 2012 on we witness the emergence of a LIMC market in the Netherlands, but it is not growing through the years. Our search of the register of the Chamber of Commerce and of internet between 2015 and 2018 documents about twenty LIMC providers active in the Netherlands. Likewise, various estimations (based on several agencies declared number of clients) established less than 1,000 users throughout the country (Böcker et al. 2019, Van Graffhorst 2014). So, despite this institutional window of opportunity and mounting problem pressure brought about by policy reforms, the niche of LIMC remains constant at a very reduced level. How can we explain this limited success of LIMC arrangements?

This working paper sets out to explore the social arguments against or in favor of using live-in migrant care arrangements. Our central questions are two: how are live-in migrant care arrangements perceived? And which are the arguments against or in favor of these arrangements? In the paper we deal both with the discourses of the general public and with a group of family caregivers of frail elderly living at home. The public opinion does not have a clear and accurate idea of this phenomenon, but rather vague, inexact notions. Media attention has been relatively moderate so that we can say that it is a phenomenon still quite unknown for the general public, but all the same a number of public discussions have dealt with it. Often known by other terms such as ‘care au-pairs’ (zorg au-pair), live-in migrant care workers have been the object of some TV programs (RTL news 2013 on Stichting Homecare, Nieuwsuur 2011), newspapers articles, studies and reports (WEMOS, Da Roit and Van Bochove), or local policy proposals (Kaya, at municipality of Amsterdam). In our paper, we pay attention to the discussions based on these sources which have followed in internet fora,

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4 This thesis suggests that the higher the availability of care services, the less likely it is that families would directly provide care informally. See Künemund & Rein 1999, Kohli 1999 for a discussion on how welfare states and long-term policies impact on family solidarity, and the crowding-in vs. crowding out effects.

5 In his study of the Austrian case, Weich (2010) found that the cultural norm of family responsibility is precisely what allows for LIMC workers to be accepted, since they are perceived as a form of family surrogate.
chat rooms, or social media. In addition to that, we are interested in the opinions and arguments of family carers of dependent relatives who do not use live-in care arrangements. As we can see them as potential users (most likely case), their reasons for not choosing transnational care arrangements (LIMC) are key to understand the general lack of success (or very moderate success) of these arrangements.

The paper is structured in the following way. In the next section we describe our research methods for data collection and analysis. After that, we present the arguments we identified, in two separated sections dealing with the results of internet analysis and focus groups. Subsequently, we compare and discuss the results of internet fora and focus groups. Our results indicate an inconsistency between them, with internet participants holding more often negative views about LIMC arrangements, and focus groups holding mixed opinions, combining negative and positive views. Discussions in focus groups mostly revolved around the boundaries and limits of family solidarity and about the additional constraints posed by the reforms of long-term care. We conclude that Dutch family carers reluctance to hire live-in migrant care workers responds to a perception of their care duty in a way that it is either not combinable with or not replaceable by semi-informal care workers.

2. Methodology

The empirical data comes from four focus groups with family carers and from an analysis of internet discussions. Focus groups are generally used to explore topics which are rather unknown (Gutiérrez Brito 2014, Ketelaar et al. 2011, Callejo 2001). The analysis of internet discussions is a recent research method with clear limitations but offering access to spontaneous discussions and exchanges of opinions otherwise unavailable. Our research design combining both techniques allows us to collect and compare opinions from the wider public (through the internet analysis) with those from a more targeted audience, particularly people who are confronted with providing care informally to their relatives or friends on a regular basis. It also enables us to combine a quantitative analysis of arguments present in internet discussions with qualitative, in-depth analysis of the focus group discussions.

Analysis of internet discussions

The internet analysis is based on 46 internet discussions6 dealing with LIMC-arrangements in the time period 2010 - 2017. These discussions were selected through the use of social media monitoring engine Coosto, which allows to detect social media posts containing certain words or combination of words. We based our search on terms used for referring to LIMC and live-in care workers, including but not limited to “care worker”, “care au pair” in Dutch.7 The software detects discussions and posts on mainstream social media platforms including Twitter and Facebook in addition to posts on internet forums and news websites. With this

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6 Internet discussions include a variable number of posts and participants. The discussions analyzed here range from 1 to 311 posts, with a mean of 46 posts per discussion. Numbers of participants are somewhat lower, with a mean of 33 per discussion.

7 The exact word combinations used to search for discussions were: “inwonende hulp”, “inwonende thuiszorg”, “inwonende hulpverlener”, “inwonende thuishulp”, “inwonende verzorg(st)er(s)”, “zorg au pair”, “zorg-aupair”, “zorgaupair”, “Poolse zorghulp”, “Poolse verzorg(st)er(s)”, “Oost-Europese zorghulp”, “Oost-Europese verzorg(st)er(s)”, “Hongaarse zorghulp”, “Hongaarse verzorg(st)er(s)”, “Slowaakse zorghulp”, “Slowaakse verzorg(st)er(s)”.

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search we identified frequent arguments in favor and against the employment of live-in migrant carers. In order to do this, we categorized all discussions according to the arguments that were used in favor of and against LIMC-arrangements.

These arguments were then categorized into dominant and secondary arguments. Dominant arguments are those that were used five times or more in a discussion; secondary arguments were mentioned less than five times. We developed this categorization due to the fact that most discussions revolved around a few arguments, with several other arguments being additionally used only once or twice. With this divide, the arguments used only once or twice were not weighed as a primary argument. If all arguments were weighed equally, the results would not truly reflect the arguments voiced in the discussion. We have decided to mark arguments mentioned five times or more as dominant due to the fact that this divide reflects our empirical findings in the best way. With the set of arguments complete, we were able to analyze which primary and secondary arguments were most common among the discussions.

Focus groups
In addition to the internet analysis, we conducted four focus groups with family carers of elderly people who did not employ live-in care workers. Our assumption was that their situation (overburdened) made it reasonable to expect that they would at least consider using this type of care arrangement (most likely case), so they would likely have ready arguments to explain or justify their preferences (why they didn’t). The group discussion was set up using an open-ended format that facilitates participants’ free association of ideas. In order not to influence the discussion, we did not start off by asking a question about LIMC arrangements. Rather, the chair formulated a broad question about the policy objective of ageing in place and their experiences with putting this into practice. Afterwards the conversation was steered towards LIMC-arrangements as a possible solution to the problems that family carers face. The first part of the focus group provided more background information regarding personal views on the care system as a whole and the individual’s perception of his/her care role and responsibilities. The second part gave people the chance to voice more specific arguments for and against LIMC-arrangements.

The basic selection criteria for the participants of the focus groups were a) to be a family carer of an old person with medium/severe care needs b) that the person would be living at home (or had been living at home till recently), c) that the care recipient would not use the services of a live-in migrant care worker. In addition, we aimed at ensuring the maximum variability among participants in terms of: level of studies, gender, age, ethnic background, geographical environment (urban/rural), and category of relative taking care of (parents, spouses, etc).

Finding participants for the focus groups proved to be much more difficult than expected. This resulted in a combination of purposeful sampling, following research goals for the self-selection of participants, and convenience sampling. We contacted participants from the social networks of friends and colleagues, and from a networking event of the municipality Amsterdam for family caregivers. For one of the groups, we used an existing network for family carers of elderly relatives with Alzheimer and dementia. This means that some of the participants knew each other, what implied pros (facilitated the conversation among them) and cons (e.g. detailed discussions of their private situations, therapy-like discussions). This potential source of bias (Ketelaar et al. 2011) was neutralized by the chair as much as possible.
The resulting focus groups still had enough differences in the participants’ profile. The characteristics of the focus groups are the following:

**Focus group 1 (FG1)** took place in Amsterdam and gathered a group of seven urban, middle-aged, highly-skilled family caregivers, most of them caring for their elderly parents. Participants were predominantly autochthonous female (five women and two men) and their ages ranked between 43 and 87. Half of them were employed, and the other half were economically inactive (retired, housewives); a majority of those who worked were self-employed.

**Focus group 2 (FG2)** assembled a group of seven family caregivers of elderly suffering Alzheimer, which took place in Arnhem, a middle-size provincial town, outside the big Dutch metropolitan area of the Randstad. The majority were 60+ autochthonous Dutch females (only one male), with mixed medium/ high education levels, already retired. Most of the participants were spouses of care recipients, who lived with their partners. Half of the care recipients had been transferred to a care/ nursing home and one had already passed away.

**Focus group 3 (FG3)** also took place in Amsterdam but had a very different profile than FG1. It gathered a group of five female, low-skilled, urban family caregivers of elderly, two of them with Surinamese background. Participants’ ages ranged between 34 and 79 years, and two of the participants were retired and three worked, of whom one self-employed. They cared for diverse categories of relatives.

Finally, **focus group 4 (FG4)** was a group of eight women with mixed skilled levels (highly-skilled and junior vocational education), and ages ranging between 37 and 78. The group also included a highly-skilled Chinese participant. Six of the caregivers care for their spouses and two for their parents. They participate in a project for innovation in the care for Alzheimer/ dementia patients, and we contacted them through the project-leader. The group discussion was arranged in Eindhoven, a city in the Southern part of the Netherlands.

**Sources of bias**

The use of the internet discussions is problematic due to the lack of control we have over the setting of the discussions. It is impossible to verify who the people participating in the discussions are, and whether or not they are a fair representation of our target group: the wider Dutch public. We thus have to limit ourselves in the generalization of our findings. At the same time, we find that the results from the internet discussions provide an interesting insight into arguments used by (a group of people) in the Dutch society. We have tried to include different societal groups by using discussion from different sources: social media networks, quality newspaper websites, online discussion fora etc.

Another potential source of bias should be taken into account when comparing the results of online and offline research. When we compared the internet and focus group Data sets we noticed that people were more likely to voice negative views in an online setting. This phenomenon dates back to early online research, where it became apparent that people were more likely to voice negative opinions online than they would offline (Chen & Hinton, 1999). According to a wide group of researchers, an increased negativity online is merely due to the extent to which people express their ‘true self’ online (Bargh, McKenna & Fitzsimmons, 2002). First, an online environment offers the individual anonymity when expressing their opinions. This allows people to express themselves without facing others’ expectations or social risks. Increased negativity would then be due to the fact that people are expressing themselves in a manner they would feel unable to when interacting in real life. Second, people will be less likely to express views in real life that are taboo or stigmatized. This means
that these views will remain hidden in real life but might be expressed online (Williams, Clausen, Robertson, Peacock & McPherson, 2012).

In the same vein, research about ‘electronic word-of-mouth’ (e-WOM communication) or the process of sharing consumers’ attitudes and behavior on the Internet, suggests that individuals with strong views about brands are more likely to disseminate such strong opinions via chat rooms and electronic consumer forums (see Lee and Hu 2004 for a review). Extremely dissatisfied customers engage in greater word-of-mouth than highly satisfied ones (Anderson 1998). This potential bias should be taken into account when considering our results.

Furthermore, we found that in the online analysis people were also more inclined to use racial slurs and xenophobic comments regarding the care workers. We did not take these comments by itself into account as they cannot be identified as arguments in themselves. The comments often tied in with dissatisfaction of Dutch care workers, which is an argument we did take into account.

3. The Dutch Long-term Care System

The Dutch long-term care system is a universalistic system which ensures access to LTC services to all residents in the country. The system is based on a LTC insurance created in 1968 to cover services for elderly care and chronic care that involve large expenses for a private insurance (Exceptional Medical Expenses Act)8. The country stands out by high level of public responsibility and public LTC expenditure (Mot et al. 2010) and a lower level of family responsibility (Mot et al. 2010, Böcker, Horn and Schweppe 2017). In addition, the Dutch LTC system can be described as a service-led system, which provides a broad range of public health and social care services. Long-term care interventions are mainly funded through income-related contributions and taxes, later supplemented by user’s co-payments.

Since the 1990s, the system is undergoing a deep policy reform, including cost-containment measures and a shift in the policy frame. The result has been labeled as a ‘restricted universalist’ system (Ranci and Pavolini 2015), which maintains a high state involvement in spite of the relative marketization and familiarization of the system. Basically, Dutch policymakers pursued policies to reduce the use of institutional care and to promote home-based care arrangements, in order to lower public expenditure on institutional care. The 2003 policy reform of the Exceptional Medical Expenses Act (AWBZ), aimed in this direction9. Residential care has been restricted for those with severe care needs, excluding lighter forms of support from the funded LTC provisions and the network of care homes targeting those with higher levels of autonomy has been partly dismantled. Partly as an effect of the de-institutionalization policies, the proportion of the 80+ population residing in residential care homes has dropped from 25 % in 1995 to 12 % in 201710.

Simultaneously, policy has aimed at containing public expenditure on home-based care, by implementing decentralization and marketization policies and raising the user charges for in-kind care services. Home care became an explicit priority since the 1980s, and in the early

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8 In Dutch, *Algemene Wet Bijzondere Ziektekosten* (AWBZ).
9 From 2015 on, the responsibilities for different LTC services -previously covered by the AWBZ- were split between the Long-term Care Act (*Wet Langdurige Zorg*), the Health Insurance Act (*Zorgverzekeringswet*) and the Social Support Act (*WMO -Wet Maatschappelijk Ondersteuning*).
10 Authors’ computations based on data of the Centraal Bureau voor de Statistiek, http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=37620&D1=0-1,11&D2=0&D3=0,66-96&D4=0,5,10,21-23&HDR=G3,T&STB=G1,G2&VW=T, data retrieved on May 15, 2018
1990s home care services expanded considerably. User charges for institutional care have also been raised. In addition, measures have been launched to promote a more efficient, sustainable system, and to privatize the provision of LTC services. A policy measure that facilitates ‘ageing at home’ arrangements are the cash benefits introduced from 2008 (2015). People with severe care needs falling under the long-term care Act (WLZ) are entitled to relatively generous cash benefits (PGB) which allows them to buy care services in the market.

Nowadays, the policy priority is to keep elderly living in their own home as long as possible, underpinned by a discourse of ‘participation society’ in which all citizens are expected to care for each other (Ministry of Health, Welfare and Sport 2013). This entails a shift towards the refamilialization of LTC policies that puts increased pressure on family members to provide care to dependent relatives (van den Broek 2016). This shift is evident in policy goals such as increasing the number of informal carers11 or keeping elderly living in their own home as long as possible (VWS, 2013). State services remain limited for those care recipients who lack a social network who can potentially provide ‘usual care’12.

Facilitated by the marketization of care and the introduction of cash allowances, from 2005 and particularly from 2010 onwards we witness the emergence of recruitment/placement agencies for live-in migrant care workers. These care providers offer around-the-clock care services for elderly and people with chronic diseases. Dutch agencies cooperate with agencies abroad to recruit migrant care workers from the new EU member states and act as intermediaries between Dutch clients and care workers. According to our survey to providers of live-in services in the Netherlands (N=10) providers specialize in carers from one or two countries, particularly Poland, Slovakia and other new EU member states. They recruit women aged 40 and older, with mostly limited training or experience in care, although some agencies can supply certified care workers. Our search of the internet, the Netherlands trade register and two online databases of care providers, found 20 such placement agencies active in the Netherlands in November 2016. Our follow-up of these agencies between 2016 and 2019 shows that the number of agencies remains constant over the years.

4. Arguments about the Use of Live-in Migrant Care Workers: Internet Fora vs. Focus Groups

Arguments displayed in internet discussions

In the 46 internet discussions analyzed, we identified 24 different arguments. Arguments combine ideas about legitimate forms of care, referring to specific laws and regulations, social norms, or beliefs of what is fair. In other words, arguments convey specific moral beliefs and care ideals, about who is responsible for elderly care, what is quality of care and which features characterize care arrangements of quality, or who should be entitled to what kind of care.

The seven most common primary arguments (used five times or more),13 are the following, in order of importance:

12 The new policy introduced the concept of ‘usual care’, which refers to “the normal, daily care that nuclear family members or other people who share a household can be expected to provide to one another” (CIZ, 2012: 9).
13 We focus here on the arguments that were central in a discussion (mentioned 5 or more times), but arguments appeared in other discussions although with less centrality. For example, as a secondary argument ‘affordability’ was present in 8 discussions.
• **Affordability of the LIMC-arrangements.** Advocators of this argument believe that LIMC arrangements are expensive and not affordable for ordinary people (‘Good idea, but not for ordinary people’). Some believe that it is not possible to finance LIMC arrangements with an LTC insurance cash-benefit or ‘personal budget’, or are simply unaware of this possibility. Implicit is the connotation of LIMC as something unjust and that entails or increases care inequalities between citizens. Rather, they somehow advocate for equality of LTC services for everybody. This discourse was the most frequently used in internet discussions. In 9 of the 46 discussions it was the primary argument used.

• **Displacement of native care professionals.** LIMC-arrangements are unfair because by hiring migrant carers, who are willing to work for lower salaries, Dutch workers will be displaced from their jobs. Implicit in the discourse of many participants is the idea that autochthonous people should have preference for getting jobs in the Netherlands over migrants (‘This is typical for the Netherlands: no jobs for our own people, they all depend on social benefits. And it looks like slavery has come back.’). This discourse was the second most frequently used, being the primary argument in 8 discussions.

• **State’s policy:** Changes in LTC policy create the need for new forms of care. Advocators of this argument are critical of the devaluation of the state’s responsibility in LTC. Implicit there is a preference for the former system with a wide network of care homes accessible for all, and in any case for professional care. Different aspects of LTC reform are criticized, but above all the deinstitutionalization, the cutbacks and the increase of families’ care responsibilities. This argument was the third most mentioned: it was one of the the primary arguments in 7 discussions.

• **Migrant carers’ Dutch language skills.** Migrant care workers are not native Dutch speakers. Advocators of this argument believe that most migrant carers have insufficient proficiency of the Dutch language. People in the Netherlands generally expect this to be a source of problems, as insufficient or misleading communication may negatively influence the provision of care. Migrant care workers must learn Dutch, in order to work in Dutch households. Particularly, some participants also associate this linguistic gap with cultural conflicts (‘It makes me cynical. [...] Real fun for all those old people who should enjoy having an au pair who doesn’t know their language or customs’). This argument was the primary topic in 6 discussions.

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14 Discussion in Kassa.vara.nl, February 2012.
15 This argument was also included in 14 discussions indirectly, as secondary argument. Among all arguments, this is the one that was used with the highest frequency, combining primary and secondary roles.
16 Discussion on Facebook page of an LIMC agency, August 2018.
17 Discussion in Trouw.nl, February 2012.
• **Labor exploitation of live-in migrant carers.** LIMC care arrangements are perceived as a business model based on the exploitation of migrant workers. People using this argument advocate that LIMC arrangements enforce basic Dutch labor laws (minimum wage, working hours, or ‘labor exploitation’). For example, they explain that migrants are exploited because they earn salaries below the minimum wage, or work beyond the maximum working hours. In our analysis, 5 discussions revolved around this argument.

• **Moral duty/guilt:** Advocators of this discourse find it immoral to outsource care to migrant care workers, because it should be either a state duty or a family/filial duty (‘The children have their hands free and can go on with their own important lives without feelings of guilt’)\(^{18}\). As a society or as individuals (children of dependent elderly parents), we must not delegate our responsibilities towards elderly by involving others in it. Outsourcing care to LIMC is sometimes understood as breaking the reciprocity rule with former generations (‘These people have struggled for what we have today, and this is how we thank them. Outrageous!’\(^{19}\)). This argument was central in 3 discussions.

• **Privacy/not wanting a stranger at home:** People using this argument oppose hiring live-in care workers because they are perceived as intruders into one’s privacy. Advocators of this argument value highly their privacy. This argument was also the primary one in 3 discussions.

We observe that four of the five most common primary arguments concern reasons against hiring a live-in migrant carer (unaffordability, displacement of native workers, low language skills and labor exploitation). Interestingly, if we aggregate the results, we observe that the most frequently used arguments in internet fora emphasize that LIMC arrangements are unfair (unaffordable, displacing Dutch workers, exploiting migrant workers, unlawful, state responsibility) or that they entail problems due to the informality of care provided (miscommunication problems, compromising privacy, lack of safety). In other words, care beliefs support state-supported, professionalized services, which are equally available for everybody. From the most common arguments, the only argument in favor of LIMC-arrangements was that these types of arrangements are somehow unavoidable due to current government policies.

Although less frequently, other arguments opposing LIMC also came forward in our research. In particular:
- LIMC possibly leading to safety issues,
- LIMC arrangements being unlawful,
- Better care is available in care homes.

Arguments in favor of LIMC arrangements were considerably less frequent. In particular, we identified the following three:
- LIMC arrangements provide elderly people with much needed company,
- LIMC does not cause displacement, because Dutch people does not want these jobs,
- LIMC arrangements do not cause language problems, non-verbal communication is more important.

\(^{18}\) Discussion at Binnenlandsbestuur.nl, august 2015.
\(^{19}\) Discussion at at5.nl, august 2015.
Arguments in focus groups discussions

Participants of the four focus groups were generally reluctant to using LIMC arrangements to care for their elderly relatives. Most focus groups’ participants had never heard about LIMC care arrangements before and had no opinion formed about the issue. The relative unawareness of these care arrangements made it difficult to capture social discourses about them. Consequently, in most group discussions it took a long time for the topic to emerge, and in some of them the topic had to be directly elicited by the chair. Not being a care arrangement present within people’s cultural repertoire, participants did not have formed opinions at hand, and had to give spontaneous reactions on the spot (participants were thinking aloud, discussing pros and cons). Initially, LIMC arrangements were received with mistrust. People showed reservations about whether it was possible/ legal at all in the Netherlands.

Overall, the first reactions in all the groups were rather negative and related to several of the arguments already seen in the internet analysis. For instance, people immediately expected that LIMC arrangements would be expensive and not affordable for everybody:

- A: Well, and you have to have money to do that.
- B: Yes, you must pay for it.
- C: Yes, it costs a lot of money (FG1).

Likewise, they assumed that only people who had a big house with a spare bedroom could afford it, implicitly pointing at an income barrier (implying that lower income would have less likelihood to be afford it). Language was also expected to become a problem, assuming that the migrant care workers would not speak Dutch, hence LIMC arrangements would only work for care recipients able to communicate in English or German. Moreover, some participants immediately associated affordable 24/7 care provided by migrant care workers with labor exploitation and with images of slavery:

I think it’s crazy that in a country, a prosperous country like the Netherlands, people ... [do that]. What do we get: a kind of slaves, that we are bringing in again? (FG3).

However, in three of the groups, after the initial negative reactions, the discussion also took a different turn considering the possible positive aspects of such an arrangement. Some family carers quickly conceived that a live-in care worker could relieve the care burden for them, allowing them to use that time for work or leisure. Moreover, it was emphasized as added value that the care recipients and LIMC workers would develop a stronger bond than with regular professional caregivers:

I think that if it is ‘live-in’, she becomes a sort of relative. [...] A new bond may develop, that is possible, if it is ‘live-in’ and you eat together, or whatever... (FG2).

Advocators and opponents of LIMC discussed the pros and cons, and a consensus was reached acknowledging that LIMC arrangements offered a good alternative for certain situations and care demands. Particularly, live-in migrant care arrangements seemed like an ‘ideal solution’ for frail elderly living on their own:

A: A friend of mine who lives just across the border, her neighbor also has someone from Poland, a nurse. She has to leave after three months [...] and then her girlfriend comes for three months, they alternate with each other. The woman is living alone and she is cared for by this nurse.
Participants in groups 1, 2 and 4 who did not want a LIMC arrangement for their relatives or eventually for themselves, explained their reluctance mostly in terms of cultural preferences. They perceived migrant care workers as strangers, and considered that having to share your private sphere with them was one of the biggest downsides of these care arrangements. This feeling of invasion in their privacy was the most unacceptable in the case of elderly couples living together. Spouses of care recipients explained that for them it was hard to accept that another woman would provide daily care for their husbands, and expected that cohabitation would trigger jealousy and confronting situations.

A: I think that, if both partners are still living together, it is very complicated if you bring another woman into the house, who cares for your husband 24 hours a day. I think that may well cause some problems. I don't think that many couples would want this.
B: Even if it would relieve them?
C: You mean transgressive behavior?
A: Well, I don't know, but that is of course possible in such a situation. And even if it relieves them...
D: It also creates tensions.
C: Yes, tensions.
A: That may be a reason for female caring partners to postpone it for as long as possible. That is my feeling.
OTHERS: Yes.
E: Only for people living on their own it is a great solution, I think.
A: Yes, for people living alone it is, but for people with a partner I see big, big... [risks]. (FG2)

Group FG3, that of low-skilled family carers in Amsterdam, did not reach a consensus on the potential positive contribution of LIMC arrangements. Rather they agreed that it was a shameful option, based on the exploitation of migrant workers, that only emerges as a consequence of policy cutbacks and the devolution of care responsibilities to families. The participants advocated for a stronger role of the state, and somehow going back to the situation previous to the policy reforms of the LTC.

It's all about money. We want to pay as little as possible, so we recruit people abroad who are willing to do the work. It is modern slavery. These people work 24 hours a day, for a pittance! (FG3)

Implicit in all of the groups, was the fact that public LTC professional services are the default option in the Netherlands, either as home care services or residential care. The general understanding is that for light care needs the available mainstream (professional) home care is enough, in combination with informal care by relatives. Professional care was ever present in all the discussions, mostly understood as the general care ideal, even when criticized. Most participants agreed with a ‘Warm modern care model’ (Hochschild 1995), an ideal of care that combines professional and family care.

Against the background of these care norms, participants of the four focus groups discussed the legitimacy of LIMC arrangements. While they used several arguments similar to those which appeared in internet fora (unaffordability, problems for privacy, communication difficulties, exploitation of migrant workers), they fundamentally anchored their care preferences in their perceptions of family reciprocity. Discussions in focus groups mostly revolved
around the boundaries and limits of family solidarity and about the additional constraints posed by the reforms of long-term care.

Focus groups participants’ perception of family solidarity has two interrelated dimensions. First, participants of all the focus groups agree on the idea that families must bear the responsibility for the care of their elderly (‘family responsibility’), although they disagree over the extent of that responsibility (strength) and the tasks that it must involve (character). Second, family carers in the focus groups perceive that they have an explicit responsibility to try to keep their elderly relatives at home (‘keeping at home duty’). Some participants put it in terms of moral duty which obliges them, some as a reciprocity norm generally felt, and yet other refer to a specific ‘promise’ made to an elderly relative.

Discussions in the focus groups mostly dealt with the different interpretations of these care norms and the contradictions that it encounters in its practical application. On the extreme, we have those who believe that the family must have the main responsibility (‘Traditional care model’, Hochschild 1995). They hold a somewhat orthodox interpretation of the ‘family duty’ and the ‘keeping at home duty’. For them, eldercare is a private issue which must be kept within the family. Although their discourses revealed some gaps in their care arrangements where a live-in care arrangement could in fact fit, for participants LIMC arrangements were not a conceivable option within the cultural repertoire of alternatives20. One of the focus group participants said that she would not want a LIMC solution because she feels that it is her duty to provide care herself:

Yes, I just think that I should take care of [partner] myself, as long as I can. [...] And I think [partner] would not like it, he would be out of his comfort zone, you know. I don’t rule out that it might go well, but my own feeling would be that I felt short if I would not take care of him myself (FG4).

Most of the participants, however, understand that family and professional care are complementary in one or another way (‘Warm modern care model’). There is variability in how they envisage the specific materialization of their carers’ role in concrete tasks, but most participants in the groups understand the cultural norm of family support in terms of affective and functional solidarity: managing care arrangements, realizing administration tasks, providing emotional support and coaching. Getting involved in personal care (washing, feeding, etc) is considered beyond family carers’ ‘normal’ responsibility, coinciding with what has been already documented in the literature (Da Roit & De Klerk 2004)21. This group has a more pragmatic interpretation of the ‘keeping at home duty’, which sees as legitimate to employ live-in migrant care workers, as long as an elderly relative can stay in the own home. In the words of a participant, her duty is to ‘let people feel at home’ (in Dutch “de mensen thuis laten voelen” FG4: P7).

This indicates that both fractions of the focus groups held different views according to the legitimacy of delegating care of relatives to hired care workers. However, in three of the

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20 Interestingly, it was associated with traditional forms of care, previous to 1960s policy reforms and the creation of the LTC system, or with other cultures of care (South Europe, China, Africa...).

21 There could be a difference between what children and spouses of elderly care recipients believe in this respect. Two women explicitly said that as spouses they believed it was their duty to personally deliver hands-on daily care to their husbands. However, some children who were the main family carer of an elderly mother or father also shared the same view, and considered it their own duty to provide physical care to their parents, keeping it away from strangers. This rather suggests that the difference is not so much the type of family tie between family carer and care recipient, but rather the ethical view about care responsibilities. Unfortunately, our data does not allow to reach conclusive answer to this issue.
focus groups (FG1, FG2, and FG4), the advocates of the traditional care model and the pragmatic positions eventually reached a consensus in two points. First, no matter in how far and in which ways the family delegates its care responsibility, the decision-making must be kept by the family carer (insofar as it is not possible to be directly held by the care recipient). Second, when LTC needs become so severe and intense that it is unbearable for the family carers, it must be delegated to professionals and institutionalization is the best option. In other words, both ‘traditional’ and ‘pragmatic’ participants understood that family care responsibility was not to be delegated to a migrant care worker. Live-in migrant care workers were not constructed as a possible family surrogate as in Austria (Weicht 2001), but understood as a type of formal caregivers with various shortcomings in their degree of professionalism. Particularly, participants considered that most live-in migrant care workers were insufficiently qualified for the job and lacked the skills to handle properly severe conditions.

That was a huge barrier for me, the washing of your husband [...], that you must leave that to another woman. The idea that another woman is now washing his buttocks. [...] Anyway, when I had finally taken that hurdle I saw that they were professional people wearing a white robe, and that also made a difference for my husband... that they were nurses with a white robe on. He was very docile and content, and I was very happy about it. (FG2).

Most group participants experienced a tension between what should be done (solidarity norms) and what is possible, although ‘pragmatic’ ones tend to voice it more openly. Family carers experienced ‘competing demands’ between work and their care responsibilities, acknowledging that caring for their elderly relatives requires them to make sacrifices, as it conflicts with personal aspirations such as building a career or maintaining relationships. Some family carers expressed feeling overburdened at times. As a result, participants considered that structural opportunities prevail over intergenerational norms, so that family carers engage in caregiving only if they are able to combine it with their job and own family (‘If we really had less time, and we chose for our work or our own family, then we would put our ‘oldie’-sorry!-in a home sooner because there is no other way’ FG1). Structured ambivalence theory (Connidis & McMullin 2002) applies here: those family carers in less advantaged positions face more contradictions and/or are less able to help their elderly relatives. Low-income participants complained about their difficulties, particularly about having to reduce their working hours to provide informal care to their relatives living at home. This is particularly obvious in FG 3, where participants criticize the state support for family carers providing informal care at home (scant income support, cut off on certain state subsidies for those bringing an elderly relative to live with them):

Grandma has to eat at 6 o’clock. So I am cooking, I am making phone calls and I have three children of my own. [...] I have to do all these things, and all these things must be done voluntarily. [...] I cannot work 40 hours and also volunteer to take care of my mother [...]. My state pension will be reduced if I take my mother to live with me, I will no longer receive rent allowance, I will no longer receive other supplements. That is too much, I don’t want to give all that up. (FG3).

This tension between norm and reality is strengthened by the reforms in the LTC system. Particularly, new policy goals of ‘ageing at home’, expecting elderly ‘to live at home as long as possible’, constitute a serious test to norms of family intergenerational solidarity. Family carers in the focus groups experienced the policy framing of ‘participation society’ as a real challenge to their role in the care of their elderly, as expected by cultural norms (normative
solidarity) and to their capacity to effectively put this in practice (functional solidarity). This assessment was shared by many participants in internet discussions.

But how do you do that? They decided that the elderly should stay in their own home, they closed down care homes, but no adequate care has been provided to replace these care homes. And the family carers are not trained. I really think something should be done about that (FG1).

5. Comparison of the Arguments in Internet and in Focus Discussions

When comparing internet fora’ and focus groups’ discourses, we observe that similar arguments are used about live-in migrant care workers. Most arguments collected in the internet analysis appear again in the group discussions. With the exception of the argument about migrant labor displacing Dutch care workers, all the other primary arguments identified in the internet analysis appear as well in the focus groups. Groups participants expressed their concerns about LIMC arrangements not being affordable for everybody, migrant carers not speaking Dutch, migrant carers being exploited, not wanting a stranger in one’s home and being against outsourcing care to LIMC, because it should be either a state duty or a family duty.

The discourses from both sources also present two fundamental differences. One is the character of the discourses, which are more ideologically-oriented in the internet chats or more practically-oriented in the focus groups. The internet analysis displays the arguments about LIMC-arrangements voiced by the wider public, who can have different degrees and forms of relation with the elderly care. Although, in many cases there is no available data about the participants’ profile, participants’ role in relation to care (care recipient, informal caregiver, professional caregiver, etc) is sometimes explicitly mentioned or implicit in their messages. The focus groups, on the other hand, explicitly gathered family carers, so the discussions reveal the considerations made by family carers when choosing the most adequate type of care arrangement for their partner, relative or friend.

Moreover, the comparison of the results reveals a difference between the overall evaluation of the arguments used by the wider public, on the one hand, and by family carers, on the other. In online discussions, a negative attitude prevails. The wider public tends to voice more arguments against hiring live-in migrant carers than arguments in favor of hiring them. Out of the five most common primary arguments (used five times or more), four displayed reasons to be against hiring a live-in migrant carer. In particular: LIMC-arrangements are not affordable for everybody, LIMC-arrangements create labor displacement of native care professionals, migrant carers have insufficient proficiency of Dutch language and migrant carers are exploited.

Among the most common arguments, the only argument in favor of LIMC-arrangements was that these types of arrangements are somehow unavoidable due to current government policies. This discourse holds that people who chooses these arrangements perceives them as the ‘only alternative’, which does not mean that they view LIMC arrangements positively. Participants tend to use the argument to convey the idea that new care alternatives are a necessary evil caused by government policies they disfavor. In one internet discussion following a news report concerning a woman who had hired a live-in migrant worker, which included criticisms from politicians on this new care alternative, a participant in the discussion wrote the following:
The government has created this problem itself. First, it fires all care workers, and demands that people take care of themselves. There are cutbacks everywhere, also in care homes. If the care would be more human there, or if there would be more home care, this would not be necessary'.

In the online discussions, the most common arguments carry thus a negative connotation. Other primary arguments used in the internet discussions against LIMC-arrangements are: family carers’ moral duty to provide care themselves, perceiving LIMC workers as intruders in one’s privacy, safety issues caused by LIMC-arrangements, understanding that care homes provide better quality of care, and LIMC-arrangements being against certain (labor) laws. These arguments outweigh further primary arguments that are posed in favor of hiring live-in migrant care workers, such as: Dutch people will not want these jobs, live-in migrant carers can be good company for elderly people coping with loneliness and language problems are not a concern.

Focus groups’ participants, on the other hand, tend to show a more positive attitude than the wider public in the internet analysis. When specifically discussing LIMC-arrangements, they voice arguments against LIMC-arrangements similar to those mentioned in online discourses are voiced. In different ways, both advocates of the ‘Traditional care model’ and of the ‘Warm modern care model’ considered that live-in migrant care workers did not fit with their care preferences and norms. However, people with different views in group discussions agreed that whenever necessary, they would rather delegate their care responsibilities to professionals. Concerning LIMC arrangements, while many family carers in the focus groups explained that they do not want to hire a LIMC for their relatives, they do see how others could benefit. Those with pragmatic views consider the possibility of employing LIMC as a way to cope with competing demands between work and care responsibilities. Particularly, they envisage LIMC arrangements as ideal solutions for some cases (e.g. elderly with dementia living alone), opening the way for a positive image of live-in migrant carers.

6. Conclusions

Recent developments in the Dutch LTC system make it reasonable to expect an increase in private services of elderly care delivered by live-in migrant care workers. However, data on the evolution of employment agencies providing LIMC workers indicate a stagnation in the volume of intermediaries, which suggests that the number of users also remains constant over the years. The objective of this paper was to analyze the perceptions about LIMC workers prevailing in Dutch society, and to identify arguments informing the decisions of family carers to decide to hire or not to hire LIMC arrangements for their dependent relatives.

Both participants in the internet discussions and in the focus groups, if confronted with the need to facilitate the provision of care for elderly relatives, were generally reluctant to using LIMC arrangements to care for their elderly relatives for different reasons. Above all, it is a relatively unknown form of care, which does not form part of people’s repertoire of care options. Information about it circulates together with myths and inexact ideas. Most participants of the focus groups did not know of its existence, and those who did had often wrong information about it (for example, that it was not possible to hire a LIMC worker with a ‘personal budget’ PGB).

Our findings reveal a relative discrepancy between the social discourses of the wider public in internet fora and the discourses of family carers in focus groups. In general terms, the wider public appears to have a more negative attitude towards the idea of LIMC-arrangements, while family carers are more open to acknowledge possible advantages. For family
carers facing competing demands, it is clear that LIMC arrangements can offer a practical solution to relieve them from care responsibilities. In the focus groups, the perception of these migrant workers is more positive, but in the light of the Dutch preference for professional care, they are seen as a ‘cheap alternative’. LIMC workers are generally associated with informal/ family-like care (sweet, nice, affective) and therefore not with formal/ professional care (not enough qualification, quality, safety).

The question then is why family carers of frail elderly living at home do not resort to live-in migrant care workers, once they decide to delegate their care tasks? On the one hand, it becomes clear that it is a matter of opportunity, as most people make use of available state-supported formal care services. On the other hand, family carers’ objections to use live-in migrant care arrangements reflect a perception of their care duty in a way that it is either not combinable or not replaceable by live-in (migrant) care workers. For the Austrian case, Weich argued that the cultural norm of family responsibility is precisely what allows for LIMC workers to be accepted, considered as a form of ‘fictive kin’. For the Dutch case, the analysis of our focus groups indicates that family carers prefer to delegate their role to a professional carer (*woman with a white robe*). LIMC are too similar to informal family carers, with possible downsides concerning safety or quality of care.

References


