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‘THIS IS AFFORDABLE!’ MONEY MATTERS IN LIVE-IN MIGRANT CARE WORKER ARRANGEMENTS

Anita Böcker, María Bruquetas-Callejo, Vincent Horn & Cornelia Schweppe[1]

Abstract

Care arrangements in which older people are cared for by live-in migrant care workers (LIMC) in private households are a growing phenomenon in many European and North American countries. This paper explores the role of money in the emergence and functioning of these arrangements. Comparing the cases of Germany and the Netherlands, it combines a governance approach and a coping strategies approach to shed light on the part played by money and financial considerations at different levels.

The paper examines first how laws and policies aimed at ensuring the financial sustainability of long-term care systems have provided incentives and opportunities for the employment of migrant carers in both countries although to different degrees. The emergence of LIMC arrangements may be an unforeseen and unintended effect of such policies, but policymakers may also tacitly accept the often semi-legal nature of these arrangements as it helps to solve care deficit problems at a low cost for the public budget.

Subsequently, the paper examines how financial considerations play a part in the decision-making processes of families that make use of these arrangements: What is the role of money and financial considerations in the decision to hire live-in migrant care workers, the choice of a particular – legal, semi-legal or illegal – employment arrangement, and decisions that may have to be made during the employment of the migrant carer? How are financial considerations balanced against the quality of the care and the quality of the migrant carers’ working conditions?

The paper is based on ca. 60 qualitative interviews with users of LIMC arrangements (mainly family carers) and key informants in Germany and the Netherlands. The interviews were conducted as part of the ESTRANCA project, which investigates the emergence and significance of transnational care arrangements.

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Key words

live-in migrant care workers; family carers; long-term care systems; cash benefits; semi-legality; Baumol effect; Germany; The Netherlands

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1. Introduction

Care arrangements in which migrants care for elderly people on a live-in basis are a growing phenomenon in various European countries. Such live-in migrant caregiver (LIMC) arrangements were first observed and are still most widespread in Southern Europe, where long-term care (LTC) for the elderly has remained largely a family responsibility and families sought ways to reduce their burden. Countries with more extensive public LTC provision have only recently seen the emergence of LIMC arrangements. The development of these transnational care arrangements thus seems to be related to the specific national LTC regime (Bettio, Simonazzi & Villa, 2006; Da Roit, 2010; Da Roit & Weicht, 2013; Österle & Bauer, 2012; Theobald, 2011; Van Hooren, 2012).

LIMC arrangements in Southern Europe tend to be in breach of labour and social law regulations and often also of immigration rules. This irregularity makes the arrangement affordable for a broader group of families and is therefore tacitly accepted by policymakers (Triandafyllidou & Ambrosini, 2011). However, both the quality of the working conditions and the quality of the care may be endangered, in particular where the care worker does not have the right to stay in the country (Anderson, 2012).

This paper explores how money and financial considerations translate into the emergence and use of LIMC arrangements in two Western European countries with different LTC regimes: Germany and the Netherlands. It combines a governance and a coping strategies approach to explore, on the one hand, how the two countries' LTC regimes – in particular policies aimed at ensuring the fiscal sustainability of the LTC system – have provided incentives for, and shaped the modes of employment of LIMCs and, on the other hand, how families in both countries decide on entering into a LIMC arrangement and choosing a specific – less or more law-compliant – employment mode against the backdrop of the respective LTC regimes. We are particularly interested in how family carers cope with having to balance cost considerations against the need to ensure fair working conditions for the LIMC, on the one hand, and good quality care for their dependent relative, on the other hand.

The paper is based on interviews with key informants (including managers of LIMC placement agencies) and users of LIMC arrangements in the two countries. The interviews were conducted as part of a research project on the emergence and significance of transnational care arrangements in Germany and the Netherlands.[2] These two countries were chosen for their different LTC regimes. One of the aims of the project was to study the relation between national LTC regimes and the occurrence and characteristics of LIMC arrangements.

The paper is structured as follows. The three sections that follow use a governance approach to describe the LIMC arrangements in Germany and the Netherlands. Section 2 briefly discusses relevant notions from the existing literature on LTC regimes and the demand for migrant care workers. Subsequent sections describe and compare the prevalence and characteristics of LIMC arrangements in Germany and the Netherlands (section 3) and how these have been influenced by the national LTC regimes (section 4). Section 5 uses a coping strategies approach and is based on our interviews with family carers in both countries. It analyses how their decisions and choices are influenced by money matters. The conclusion takes the

[2] The ESTRANCA (Emergence and Significance of Transnational Care Arrangements) project was financed by the German Research Foundation and the Netherlands Organisation for Scientific Research in the framework of the Open Research Area (ORA) programme. The project was a cooperation between Johannes Gutenberg University (Mainz, Germany) and Radboud University (Nijmegen, the Netherlands).

results of the governance approach and the coping strategies approach together and evaluates and compares the relative role of financial considerations in the emergence and use of LIMC arrangements in Germany and the Netherlands.

2. Long-term care regimes, the 'Baumol effect' and the demand for migrant carers

LTC involves a variety of services which support the needs of people with chronic illnesses or disabilities that affect their ability to perform activities of daily living on their own. LTC systems in European countries are typically a mix of state, family and market services (Bettio & Verashchagina, 2012). However, the division of costs and responsibilities differs from country to country. National LTC systems can be placed on a spectrum with informal care-led regimes at one end and service-led regimes at the opposite end. Informal-care-led regimes are characterised by a heavy reliance on family carers and limited state responsibility for LTC. The family is responsible for providing care or buying private professional care services; the state may then subsidise some of the financial cost. Public care services are only accessible for people in need if their family cannot provide care or pay for private care services. In countries with service-led regimes, by contrast, the LTC mix is dominated by public or publicly funded services. The responsibility of the family has been reduced through the implementation of universal rights to public in-kind care services for people in need regardless of their family circumstances. Most LTC systems fall somewhere in between these extremes and the trend, moreover, appears to be toward convergence (Pavolini & Ranci, 2008; Anderson, 2012). Another nuance is that service-led systems differ in the way care services are provided. Services may be provided directly by the state (social-democratic welfare systems) or the state may outsource them to private care services providers (liberal welfare systems). The Dutch LTC regime can be described as a (predominantly) service-led system in which care services are increasingly outsourced to private providers; the German LTC regime can be characterised as a (predominantly) informal care-led system.

Both informal care-led and service-led LTC systems are facing strains due to population ageing, changing family structures and the increased labour market participation of women, who traditionally provide the bulk of informal care. The provision of LTC depends on high labour inputs. In the formal LTC sector, labour productivity gains are hardly possible because technological innovations can only to a limited extent replace human care workers. The sector can be seen as suffering from 'Baumol's cost disease': wages in the sector tend to rise in line with wages in sectors with higher productivity gains – because if they don't, the jobs in this sector will be avoided by anybody who has alternatives – leading to increasing labour costs per unit of output (Baumol & Bowen, 1966; Baumol, 2012; Sciortino & Finotelli, 2015; Mosca et al., 2017).

Especially in countries with service-led models, this poses a problem to policy makers who have to find ways to ensure the fiscal sustainability of the LTC system. If productivity increases and unit costs reductions are hardly possible, the only other option may be to increase private funding, e.g., by limiting entitlements or increasing user contributions (Mosca et al., 2017). Such measures are unpopular with the public, however. In countries with informal care-led systems, the Baumol effect also poses a problem to families. Families in these countries can be compared to general contractors; they constantly make make-or-buy choices, deciding whether to produce a particular service themselves or to outsource it. Care services which cannot be provided within the family have to be purchased on the market.

However, if the wages of care workers follow the rise in wages in other sectors, most families will not be able to pay for private professional care services (Sciortino & Finotelli, 2015).

As has been argued by Sciortino and Finotelli (2015), Baumol's cost disease can hardly be escaped in a closed system, and that is where labour immigration comes in. Hiring migrant care workers who are willing to accept wages that are not acceptable to native workers is a way to escape the Baumol effect. Migrants may be willing to accept lower wages because the pay is still better than for jobs in their country of origin and/or because they are barred from other, better paid jobs in the host country due to discrimination or, in case they are undocumented, their immigration status (cf. Van Hooren, 2012).

In some countries with informal care-led systems, Italy being the clearest example, the employment of migrants as private carers for older people has become widespread and crucial to the sustainability of the LTC system. The migrant carers often provide care around the clock and on a live-in basis. With regard to Italy, it has been argued that the traditional family model of care is being replaced by a 'migrant in the family' model of care (Bettio, Simonazzi & Villa, 2006; Ambrosini, 2015). In countries with service-led systems, migrant care workers may be used to fill labour shortages in the formal care sector and contain the costs of LTC provision. This appears to occur particularly where governments outsource publicly funded care services to private providers, the UK being the clearest example. The UK has seen the emergence of what has been called a 'migrant in the market' model of care because the private care sector pays its care workers worse than the public sector and therefore experiences difficulties recruiting and retaining native carers (Van Hooren, 2012). According to Sciortino and Finotelli, there are signs of a growing demand for migrant care workers even in countries with social-democratic systems. They conclude that 'the demand for foreign care workers is not an occasional pathology but rather a structural feature of contemporary welfare states, a resource to be taken into account in any debate about its future' (Sciortino & Finotelli, 2015, p. 202-203).

The Baumol effect explains why many countries have a demand for migrant care workers, but it does not provide insight in what happens at the micro-level. How do families with elderly members with increasing care needs decide on employing a LIMC and on how to employ her? What role do financial considerations and concerns play in these decisions and in the day-to-day management of the care arrangement? How are financial considerations reconciled with other concerns, in particular regarding the migrant carers' working conditions and the quality of the care? This paper thus contributes to the literature by focusing on families as employers of migrant care workers.

3. The markets for LIMC arrangements in Germany and the Netherlands

LIMC arrangements have become widely used in Germany. A recent estimate is that between 100,000 and 300,000 elderly Germans are cared for in their own home by LIMCs (Arend & Klie, 2017). A survey among households with an elderly member in need of care found that 8 % made use of LIMC arrangements; among households with care recipients with the heaviest care needs, the percentage was 22 % (Hielscher, Kirchen-Peters & Nock, 2017). Nearly all the LIMCs are women, mostly middle-age, from Poland and other Central and Eastern European (CEE) EU member states.

A market for LIMC arrangements started to develop already in the 1990s, before the EU enlargement towards Central and Eastern Europe. Precisely at the time when in Germany

many women entered the labour market, women in Poland and other CEE countries were pushed out of employment. Polish women entered Germany on tourist visas and started to work informally, without work permits, as private carers for elderly Germans. They were recruited through informal networks, some of which developed through the agency of, e.g., catholic organisations. These networks organised rotation systems in which female relatives, friends or colleagues replaced each other every three months or so (Lutz & Palenga-Möllenbeck, 2010; Emunds, 2016).

Private LIMC placement agencies started to mushroom in Germany after 2000, as the EU enlargement approached. There are currently more than 250 agencies active in the country (Stiftung Warentest, 2017). In 2011, Germany lifted all restrictions on the movement of workers from the CEE countries which joined the EU in 2004. However, the option to employ care workers as EU workers is not popular with placement agencies. The business model of most agencies appears to be based on evading German labour and social law. They have partner companies in Poland and other CEE countries which act as employers and send the care workers to Germany under the EU posted workers directive. Posted workers are not covered by their host member state's (in this case Germany's) social security system, they remain insured in their home country. Apart from certain key provisions, German labour law is not applicable either. Therefore, in many instances, posted workers are cheaper than local workers or EU workers (who must be treated on an equal footing with local workers). The partner companies in the CEE countries may also just recruit the care workers and send them to Germany as self-employed workers. The latter employment mode appears to have become more popular after the introduction, in 2015, of a statutory minimum wage in Germany (minimum rates of pay are also applicable to posted workers). Agencies may also opt for this employment mode because maximum work periods and minimum rest periods are not applicable to self-employed workers. For a minority of the migrant carers, the agency in Germany acts as employer (Krawietz, 2014; Stiftung Warentest, 2017; Emunds, 2016).

The option to employ migrant carers as EU workers is not much used by German families either. Recruitment of LIMCs through informal networks has continued. It is estimated that more than half, perhaps even 90 % of the LIMCs in the country are directly employed by families – nearly always on an informal basis (Krawietz 2014; Emunds 2016; Stiftung Warentest 2017). As EU citizens, the LIMCs have the right to stay and also to work in Germany, but the informal employment mode entails evasion of taxation and social contributions and avoidance of formal regulation more generally. This informality or semi-legality makes the arrangement affordable for a broader group of families.

In the Netherlands, LIMC arrangements are a recent and still very small-scale phenomenon. Our estimate is that less than thousand elderly Dutch are cared for by LIMCs, nearly all of whom are women from CEE EU member states (cf. Van Grafhorst, 2014; Da Roit & Van Bochove, 2017). Unlike in Germany, the LIMC market in the Netherlands is based to a large extent on the activity of private placement agencies. The first agencies started their business shortly after the 2004 enlargement of the EU. Some of them originally started as temporary employment agencies for workers from Central and Eastern Europe, as au pair agencies or as private home care agencies. The number of LIMC agencies has grown, particularly since 2010, to around two dozen agencies currently. Like in Germany, most agencies have partner companies in CEE EU member states and the LIMCs are often employed as posted workers. However, some agencies operate differently, either themselves employing the LIMCs or asking their clients to act as employers or asking the LIMCs to work on a self-employed basis. Direct

recruitment and employment by families are rare and so far we have not found cases of employment on a purely informal basis in the Netherlands (cf. Da Roit & Van Bochove, 2017).

Not only are LIMC arrangements much more common in Germany than in the Netherlands, the employment modes also differ between the two countries. In the next section, we argue that these differences can be explained to a large extent incentives and barriers in the national LTC regimes.

4. Incentives and barriers in the German and Dutch LTC regimes

The differences in the use of LIMC arrangements in Germany and the Netherlands can hardly be explained by labour immigration policies and programmes. In the years before the EU enlargement, Germany implemented a recruitment programme for *Haushaltshilfen* (home helps) from CEE countries to ease the burden on families with members in need of care, while the Netherlands experimented with a bilateral agreement to recruit Polish nurses to work in care homes. However, neither programme was successful (Lutz, 2009; Lutz & Palenga-Möllenbeck, 2010; Theobald, 2012; De Lange & Pool, 2004; De Lange, 2007).

The different size and characteristics of the LIMC markets in Germany and the Netherlands can be explained to a large extent by the national LTC regimes.

The German LTC regime is characterised by a relatively high level of family responsibility for LTC, a strong preference for home-based care, a relatively low level of public LTC expenditure and the availability of relatively unregulated cash-for-care benefits. These characteristics have favoured a growing reliance on LIMCs (Da Roit & Le Bihan, 2010; Theobald 2011; Böcker, Horn & Schweppe, 2017). The German LTC insurance scheme has from its beginning promoted the use of cash-for-care benefits (*Pflegegeld*). Although these cash benefits are relatively low (max. 901 euros per month) as compared to the costs of in-kind benefits, 80 % of the LTC insurance beneficiaries opt for cash benefits (BMG, 2017). The cash benefits are paid directly to the dependent person and their use is left to the recipient's discretion. The only form of control is that recipients are visited by professional care workers twice a year to assess the quality of care. Cash benefits are often used to pay family members or other informal carers. The strong preference for (relatively low) cash benefits has helped to maintain the fiscal sustainability of the German LTC insurance scheme (Nadash et al., 2012). On the other hand, the German cash benefit scheme has been criticised for reinforcing traditional gender roles, thereby impeding the growth, both in size and quality, of the formal LTC sector, and for creating a grey or black market for irregularly employed (migrant) care workers as well as a two-tiered system in which only wealthy households can pay professional care services (Österle & Hammer, 2007; Da Roit & Le Bihan, 2010; Nadash et al., 2012).

Compared to the German regime, the Dutch LTC regime is characterised by a high level of public expenditure and a lower level of family responsibility for LTC, a high level of use of in-kind benefits and other publicly funded care services and a stronger preference for formal care services (Mot, 2010; Böcker, Horn & Schweppe, 2017). Cash-for-care benefits ('personal care budgets') were a late addition to the Dutch LTC insurance scheme. They were introduced primarily to give more freedom of choice to LTC insurance beneficiaries. The Dutch personal care budgets are much more generous (on average amounting to 3,400 euros per month, but potentially much higher[3]) than the German cash benefits, but their use is tightly regulated

[3] Users of LTC insurance benefits do have to pay a personal contribution, the amount of which depends on their taxable income, capital and living situation. In 2019, the minimum contribution was 23 euros and the maximum contribution was 862 euros per month.

and controlled. Beneficiaries have to draw up a budget plan stating what care services they intend to buy from which care provider(s) and they must sign a contract with each care provider, which must include a description of the care services they will provide. The Social Insurance Bank then pays the care providers out of the beneficiary's budget. Unlike the German cash benefits, the Dutch personal care budgets have not resulted in cost containment. A recent study found that they have rather increased the total cost of LTC as they 'appeal to a group of people who would have not applied for care (in-kind) if they had not had the option of having their own budget' (Mosca et al., 2017, p. 201) However, most LTC insurance beneficiaries still opt for in-kind benefits. In 2016, only 4.7 % of LTC recipients aged 65 and over had a personal care budget (MLZ, 2018, own computations).

Over the last decades, Dutch policymakers have pursued policies to reduce the use of residential care (for example by raising user charges) and promote home-based care arrangements, both to lower public expenditure on residential care and to meet the growing preference for home-based care.[4] These policy reforms, in combination with the EU enlargement to Central and Eastern Europe, have been perceived as opportunities by entrepreneurs who saw a market for LIMC arrangements. The placement agencies in the Netherlands target clients who are eligible for LTC insurance benefits because they need 24/7 assistance or supervision. Many agencies advertise that the costs of a LIMC arrangement can be paid from the client's personal care budget. Nevertheless, the demand for LIMC arrangements in the Netherlands is as yet small in comparison to Germany.

In Germany, politicians and public authorities have tacitly accepted the semi-legal nature of many LIMC arrangements. The role of German state has been characterized as one of complicity: 'knowing and pretending ignorance at the same time; acting officially in a restrictive way, while tacitly accepting the violation of self-made rules' (Lutz & Palenga Möllenback, 2010, p. 426). The situation of semi-legality helps to solve, at least in the short term, care-deficit problems at a low cost for the public budget. With regard to the Netherlands, our interviews with public bodies and LIMC placement agencies showed that Dutch officials do see (potential) problems, but LIMC arrangements are not a priority issue, because the numbers are small and the work is carried out in private households. Nevertheless, both the healthcare inspectorate and the labour inspectorate have been actively inspecting some of the placement agencies. One agency ceased its activities after having been put under enhanced surveillance by the healthcare inspectorate.[5] Also telling is the fact that Dutch MPs have asked questions about LIMC arrangements and placement agencies at least as often as their German counterparts. In both countries, MPs' questions mostly concerned the legality of the working conditions and/or employment modes of LIMCs and the supervision of LIMC placement agencies. Dutch MPs were also concerned that the deployment of migrant caregivers would lead to displacement of Dutch care workers and substandard care.[6] The same concerns were also expressed in posts and discussions on internet forums and social media (Böcker & Bruquetas-Callejo 2019; Bruquetas-Callejo & Noordhuizen 2020; Bomert 2020).

[4] The term residential care refers to long-term care given to elderly people who do not stay in their own home or family home, but in a care home or nursing home.

[5] Aanwijzing voor De Wit Thuiszorg B.V. beëindigd, Press release Health Inspectorate, 25 September 2017, https://www.igj.nl/zorgsectoren/zorg-thuis/nieuws/2017/09/25/aanwijzing-de-wit-thuiszorg-beeindigd

[6] Dutch MPs' questions: Aanhangsel Handelingen II 2008/09, 3765; Aanhangsel Handelingen II 2009/10, nr. 146; Handelingen II 2013/14, 10, item 5; Aanhangsel Handelingen II 2016/17, nr. 1976; Kamerstukken II 2017/18, 23 235, p. 176; Aanhangsel Handelingen II 2017/18, 2960. Examples of German MPs' questions: Bundestagsdrucksache 17/8373, http://dip21.bundestag.de/dip21/btd/17/083/1708373.pdf

In conclusion, the development of a large, and to a large extent grey, LIMC market in Germany can be seen as an effect of the strong preference for home-based care, the relatively low level of public LTC expenditure, the availability of relatively unregulated cash benefits and the attitude of tacit acceptance of politicians and public authorities. In the Netherlands, the emergence of a still very small LIMC market can be seen as an unintended side effect of policies aimed at ensuring the financial sustainability of the LTC system. These policies have moved the Dutch system in the direction of the German system. However, the Dutch cash benefits remain tightly regulated and the trend is toward more, not less, controls. This explains why a grey LIMC market is less likely to develop in the Netherlands.

5. Money matters in families' decision-making processes

Cash benefits can be used by governments to contain the costs of LTC. Although Germany is more clearly a case in point than the Netherlands, both countries have set the level of LTC cash benefits below the cost of in-kind LTC services. Family carers are thus compelled to develop their own strategies to contain the costs of their relative's care package. In this section, we turn to the decision-making processes of families that make use of LIMC arrangements. As we will see, using a LIMC arrangement may in itself be a cost containment strategy. We successively analyse the role of money and financial considerations in the decision to enter into a LIMC arrangement, the choice of a specific employment mode, and decisions that may have to be made subsequently, for example when the care needs of the care recipient increase. In all these decisions, cost considerations may have to be balanced against considerations about the quality of the care and the LIMC's working conditions.

This section is based on our interviews with family carers[7] in Germany and the Netherlands. The interviews were conducted between May 2016 and March 2018. We interviewed 27 family carers who had arranged a LIMC arrangement for an elderly relative, 14 in Germany and 13 in the Netherlands. In most cases, the family carer was a son or daughter of the elderly care recipient. The socio-economic profiles of the German respondents varied considerably. The majority of the Dutch respondents were highly educated and employed full-time. Recruiting respondents was difficult in both countries, although for different reasons. In the Netherlands, the main obstacle was that LIMC arrangements are still rare, so that snowballing was of little use. Most respondents were recruited via LIMC placement agencies. In Germany, the main obstacle was the respondents' reluctance to participate because their LIMCs were working undeclared. In both countries, all LIMCs came from CEE EU member states. In Germany, the majority came from Poland. In the Netherlands, the majority came from Slovakia. Most of the care recipients were men or (more often) women in their 70s or 80s. Most of them needed continuous supervision and help with activities of daily living.

The decision to enter into a LIMC arrangement

When the care needs of an elderly dependent increase to the point that they can no longer be met within the family or through a limited amount of home care or day care services, family carers are faced with the challenge of reconciling availability, acceptability and affordability.

[7] We use the term family carer for people who look after a parent or partner who needs help because of illness, frailty or disability. The care they provide can range from help with everyday tasks and personal care, to emotional support or helping with tasks like banking and housework.

The parents or spouses of our respondents suffered from conditions such as dementia, Parkinson's disease, old-age frailty or a combination of these. Most family carers responded to their dependent's increasing care needs by organising a mix of formal home-based care and informal (family) care. Residential care was rejected by them because it was not compatible with their (or their dependent's) preference for a more personalised and holistic model of care. In Germany, the high user charges were another important reason to avoid residential care.

Coming to the point when their parent or spouse needed continuous care or supervision, family carers in both countries were faced with the problem that regular home care services providers can not provide 24/7 care – at least not at an affordable price. Family carers in the Netherlands were disappointed to discover that the Dutch LTC insurance offers neither 24/7 home care services in kind, nor cash benefits that are high enough to buy 24/7 care services from regular home care providers. Many were advised to move their parent or spouse to a care home. In Germany, family carers who contacted home care services providers discovered that 24/7 home-based care would be even much more expensive than residential care.

As they found regular 24/7 home care services to be 'unaffordable', 'prohibitively expensive' or 'certainly not sustainable in the longer run', family carers in both countries searched for alternative care arrangements, which had to be affordable as well as compatible with their (dependent's) care preferences. They found that a LIMC arrangement could fulfill both requirements. Family carers in Germany learnt about this possibility through various channels, including neighbours and friends as well as 'trust intermediaries', i.e., family doctors, social service departments in hospitals, regular home care services providers, or other persons or organisations endowed with moral or professional authority (cf. Ambrosini, 2015). These intermediaries sometimes also put the family carer in contact with the LIMC to be hired. In the Netherlands, LIMC arrangements are much less known. Most of our Dutch respondents discovered this possibility by searching the internet and landing on the websites of LIMC placement agencies. Several Dutch family carers related how relieved they were to find out that a LIMC arrangement would not only meet their dependent's care needs and preferences, but was also affordable.

The choice of a specific LIMC arrangement

In combination with the preference for home-based care, affordability is an important motive in the decision to enter inter a LIMC arrangement. However, the costs of LIMC arrangements vary and depend, among other things, on how the migrant carer is employed, whether she (or he) is hired through an agency, and on her (or his) skills and qualifications. For example, an EU worker arrangement costs more than an arrangement with posted or self-employed workers, and care workers who have formal nursing qualifications or who speak the client's language cost more than care workers who do not have such skills or qualifications. Users can thus to a certain extent adapt the costs of the arrangement to what they are able and willing to pay.

Many of our German respondents hired their relative's LIMCs directly and on an informal basis. These respondents often pointed out that hiring through an agency would be much costlier. For some families, employing their LIMCs informally, i.e., undeclared, was the only affordable option. Families who hired their LIMCs through a German placement agency tended to have larger financial resources. They opted for hiring through an agency because it ensured continuity of care (replacement of the case worker in case of illness, during holidays, etc.) and a higher degree of legality. Regardless of the mode of employment, placement

agencies were criticised as 'greedy'. Instead of using an agency in Germany, families may directly use an agency abroad. One family carer reported that she hired her dependent's LIMC through an agency in Slovakia because she did not want to support the business model of German placement agencies. Another family carer reported that she initially hired through an agency in Romania, which sent the LIMC as 'self-employed' worker to Germany. The respondent was not happy with this employment mode, she was afraid of the family's reputation in the village, and therefore decided to employ the LIMC regularly, as *Haushaltshilfe*. Interestingly, in some cases, the employment mode had been determined by opportunity rather than the family carer's choice. Recommendations by neighbours, relatives or friends led to the decision to employ a specific LIMC, with the family carer accepting the mode of employment chosen by this care worker or the agency through which she worked.

In the Netherlands, nearly all respondents hired their relative's LIMCs through a placement agency. Initially, they simply were not aware of other possibilities. Later on several Dutch respondents considered the possibility of hiring the LIMCs directly. They found the margin between what the agency charged them and what the carers earned excessively large and calculated that they could lower their costs as well as offer the carers a better pay by circumventing the agency and entering into direct negotiations with the LIMCs. However, most of them decided against it because the agency ensured continuity and because they dreaded the administrative burden. Moreover, they did not want to become employers. As one family carer explained: 'As a family, we are just a buying party, we have a budget with which we buy care […], but we do not employ anybody.' When LIMCs are hired through an agency, the mode of employment is determined by the agency. However, several family carers had consciously looked for an agency that offers its LIMCs good working conditions and/or a Dutch employment contract. They said they preferred to pay a higher fee rather than making use of LIMCs who are employed by a foreign agency.

Cost considerations may thus also weigh heavily in the choice of a specific employment mode. Having sufficient financial resources enables care recipients and their families to reconcile affordability with a higher degree of legality and/or a greater assurance of continuity. This holds true for families in both countries. However, as the Dutch LTC insurance scheme provides higher levels of benefits than the German one, private resources tend to be a more decisive factor in Germany than in the Netherlands.

The day-to-day management of the LIMC arrangement

In both countries, LTC insurance cash benefits can be (and are) used to pay at least part of the costs of the LIMC arrangement. However, as the German LTC cash benefits are lower than the Dutch ones, German users are faced with larger gaps between their cash benefits and their care costs.

In the Netherlands, where in-kind LTC benefits are more common, some respondents learnt about the possibility of applying for a personal care budget from the LIMC placement agency; the agency sometimes also helped with the application. In most cases, the cash benefit covered a large part and in some cases all the costs of the LIMC arrangement. In Germany, by contrast, all users had to draw upon private resources to cover the costs of the LIMC arrangement. In both countries, the actual amount and proportion paid by the users depended on the choices they made, both with regard to the specific LIMC arrangement (the mode of employment and the skills and qualifications of the migrant carer) and with regard to buying additional care services to relieve the migrant carer or themselves.

Generally, sons and daughters did not have problems with using their parents' savings to pay for the LIMC arrangement and other care services. They tended to say that it was their parents' money and that they found it important that their parents' care needs and preferences were met. Some of them added, however, that they were not prepared to contribute towards their parents' care costs with their own money. Several sons and daughters in the Netherlands noted, moreover, that the LTC insurance scheme should have covered all the costs. Our Dutch respondents tended to hold the state responsible for the provision of LTC for the elderly. Their German counterparts rather seemed to accept their having to draw upon private resources as a fact of life, though a few of them did state that the state should bear a larger part of the costs of LTC for the elderly.

As stated above, family carers have to contain the costs of their relative's care package, and using a LIMC arrangement may in itself be a cost containment strategy. Additional strategies are developed in the day-to-day management of the care package. Several family carers related in detail how they managed to 'stretch' their relative's cash benefit. For example, one family carer asked her mother's LIMC to take her weekly day off on a weekday, as respite care services would be more expensive on weekend days. Another strategy to keep the care package affordable is to constantly make make-or-buy choices. Our interviews showed that LIMC arrangements are nearly always supplemented by informal care and sometimes also by formal care services. Family carers in both countries remained involved – in some cases heavily – in the care of their elderly relative. Besides acting as 'care manager' for their parent or spouse, family carers in Germany often also provided hands-on care and social and emotional support, whereas their counterparts in the Netherlands provided social and emotional support and in some cases also hands-on care. Make-or-buy decisions were made, for example, when the dependent's care needs required the presence of two caregivers at various times of the day. If buying formal home care services went beyond the care recipient's financial means, so that sons and daughters would have to contribute with their own money, the respondents and other family members took it upon themselves to assist the LIMC. Family carers often also replaced the LIMC during her weekly day off. This strategy would allow to achieve two goals in one strike, saving costs and fulfilling their personal desire to spend time with their relative. Of course, having sufficient financial resources enables care recipients and their family members to base their make-or-buy decisions not only on cost considerations, but also on quality considerations and personal preferences.

Financial resources may also play a role in maintaining or improving the quality of the LIMC arrangement. Respondents in both countries reported making gifts or extra payments to the migrant carers, for example when they temporarily returned home, to acknowledge their good work and to entice them to come back. In their role as care managers, family carers may also have to deal with requests for pay rises from their relative's LIMC. Care needs tend to increase over time, altering the balance between the LIMC's workload and pay. In such situations, respondents in both countries were inclined to pay more under the motto 'never change a well-functioning care arrangement'. Family carers in Germany tended to accept requests for pay rises from their irregularly employed LIMCs. They felt they were in the weaker position as they depended more on the LIMC than vice versa. In both countries, respondents who hired LIMCs through placement agencies, negotiated with the agency about a pay rise for the LIMC or paid her something extra themselves. They sometimes also negotiated other solutions with the LIMC. For example, one family carer whose mother started to keep the LIMC awake at night first tried to convince the LIMC to catch up on some sleep during the day. When the LIMC objected, the family carer decided to buy a few night shifts

per week from a regular home care provider. She was able to pay for these shifts thanks to the fact that her mother's cash benefit had been raised.

Family carers in the Netherlands, nearly all of whom hired their LIMCs through placement agencies, often became aware after a while that there was a rather wide gap between what they paid the agency and what the LIMC earned. In some cases, the LIMCs themselves complained about their pay. In these situations, too, family carers were inclined to arrange a pay rise with the agency or to pay the LIMC something extra themselves. There were also respondents who had switched, together with the LIMC, to another agency, or who were considering such a switch in order to ensure the LIMC a better pay.

In short, money continues to play a role after the decision to enter into a LIMC arrangement. It is a means to manage, maintain and improve the quality of the arrangement.

Balancing financial and other considerations

The literature on live-in migrant care workers sees the lack of controls as a weakness of LIMC arrangements. It would compromise both the quality of the care and the quality of the working conditions of the carers. Our interviews showed that family carers tend to downplay both dangers.

Respondents in both countries were aware that LIMCs are usually not trained nurses, but they did not think that the quality of the care is less, or less guaranteed, than with residential care or professional home-based care. Several respondents thought that the risk of errors and accidents is higher in care homes, where a patient is cared for by many different care workers. Moreover, most respondents adhered to a care ideal in which social and emotional aspects weigh more heavily than compliance with professional nursing standards.

Respondents in both countries also downplayed the danger of exploitation of LIMCs. They tended to see the LIMC arrangement as a win-win situation: the care recipient could stay in his or her familiar surroundings; the migrant carer earned much more than she could in her home country; and the family had an affordable solution for their relative's care needs. In both countries, only few family carers had moral problems with the LIMC being on call more or less around the clock while being paid on the basis of a 40 to 48 hours' working week. Common justifications given were that the LIMCs do not work all the time, that they get free board and lodging, that they earn much more than what they could earn in their country of origin, and, as a Dutch family carer put it: 'That is what makes this arrangement affordable' (see also Horn et al. 2019).

In short, family carers do not see affordability as incompatible with good care and fair working conditions. Nevertheless, in everyday reality, they are sometimes faced with challenges in reconciling these different aspects. Several Dutch respondents did have doubts about whether the agency through which they hired their relative's LIMCs complied with all relevant laws and regulations. They argued, however, that they were only buyers of care services and therefore could not be held responsible for ensuring a law-compliant employment mode. In their view, the placement agencies have prime responsibility for the working conditions and the state should control the agencies. In Germany, family carers who hired their relative's migrant carers on an informal basis showed little concern about being detected and held responsible for violating labour and social security law regulations.[8] They nonetheless deployed various justifications for their resorting to an irregular arrangement. For one thing, they blamed the country's LTC regime, pointing out that the system would collapse if the

[8] This could be due to a bias in our sample, though, since those who worry about legal consequences are presumably less likely to consent to being interviewed.

authorities started to enforce labour and social security law regulations. For another thing, they diffused their own responsibility by pointing to the 'thousands of others' who were doing the same. In addition, they blamed LIMC placement agencies for being 'greedy'. One family carer explained that the migrant carer herself did not want to be employed on a formal basis, because it would reduce her net income by the income tax and social security contributions. However, the LIMC was present at this conversation and her reaction showed that this was perhaps not an adequate description of her preferences.

The interviews showed that the quality of the care weighs heavily in family carers' decisionmaking. For respondents who hired their relative's carers through an agency, the price was not the most important consideration in choosing an agency and a specific LIMC arrangement. They were willing to pay more – provided, of course, that they had the means – for LIMCs who were experienced and who could communicate with their relative in his or her own language. Moreover, regardless of the mode of employment, family carers in both countries were prepared to accept requests for pay rises because they did not want to risk spoiling a well-functioning care arrangement.

Some family carers were also willing to pay more for fair and law-compliant working conditions. As mentioned, several Dutch respondents consciously looked for a placement agency that offers its LIMCs good working conditions and/or a Dutch employment contract. Compliance with social and labour law regulations was also important for the German family carer who decided to employ her relative's carer as a regular *Haushaltshilfe.* German respondents who decided against hiring LIMCs on an informal basis, did so because they wanted continuity but in some cases also because they did not want to be involved in an irregular arrangement. The latter respondents were not necessarily afraid of legal sanctions; their family's reputation and their own moral standards seemed to play a larger role. As we saw above, however, families with limited financial means did not have another option than to resort to irregular arrangements.

Family carers clearly see it as their first priority, and responsibility, to ensure that their dependent gets good and sufficient care. Several Dutch family carers therefore decided against employing their relative's LIMCs directly or switching to another placement agency – although it would have have enabled them to offer the LIMCs a better pay – because they were satisfied with the quality of the current care arrangement.

6. Conclusions

In many European welfare states, migrant care workers are recruited as a way to manage strains caused by the growing scarcity of informal and professional carers. This paper has concentrated on the deployment of live-in migrant carers to provide long-term care to elderly people in Germany and the Netherlands, focusing specifically on the role of national long-term care regimes, on the one hand, and family carers as involuntary employers, on the other hand.

In the first part of the paper we used a governance approach to describe and explain the emergence and significance of LIMC arrangements in the two countries. The public LTC schemes of both countries do not provide 24/7 home-based care or supervision. Paying Dutch or German care workers to provide these services comes at a price that is not affordable for all but the most wealthy families. This explains why in both countries a market for LIMC arrangements has developed. However, the scale and structural characteristics differ greatly. Germany has seen the development of a large – and to a large extent grey – market,

with many families hiring LIMCs for their elderly relatives on an informal basis. The market in the Netherlands is very small and largely based on the activities of private placement agencies.

These differences can be explained by the different national LTC regimes. The German LTC regime relies heavily on home-based and informal (family) care. User contributions for residential care and other in-kind LTC insurance benefits are relatively high. Cash benefits are both relatively low and relatively unregulated. This leaves many families with few other options than to purchase care services which they cannot provide within the family on an informal basis. Hiring live-in migrant carers is just one of the types of low-cost informal care arrangements organised by German families. The development of a grey market for LIMC arrangements has been perceived and (tacitly) accepted by policymakers as helping to ensure the financial sustainability of the LTC system.

The Dutch LTC regime, by contrast, relies more heavily on formal and residential care. The public LTC scheme ensures the availability of affordable in-kind care services. Policies aimed at reducing the use of residential care, on the one hand, and the growing preference of elderly people for home-based care, on the other hand, induce more and more families to apply for home-based care services for their elderly relatives. However, when the latter start to need 24/7 care or supervision, residential care is still the most common option as the Dutch LTC insurance cannot provide 24/7 home care services in kind. Relatively few Dutch families opt for LTC cash benefits, which are relatively high but also tightly regulated. A large grey market for LIMC arrangements is therefore less likely to develop in the Netherlands.

In the second part of the paper we used a coping strategies approach to analyse the role of financial considerations and resources in the choices and decisions of family carers who hire LIMCs for their elderly relatives. In both countries, the use of an LIMC arrangement is in itself a way to solve what could be called the trilemma of availability, acceptability and affordability of care services. Affordability on its own does not explain why German and Dutch family carers opt for an LIMC arrangement. It is rather in combination with acceptability: LIMC arrangements offer a form of care close to the users' preferences – a form of care that is otherwise not available, at least not at an affordable price. This being said, the less generous German LTC scheme creates a context in which LTC recipients and their families face sharper affordability issues than their counterparts in the Netherlands.

Cash benefits compel LTC recipients and their families to develop their own strategies to contain the costs of the care arrangement. While this is true in both countries, the lower German cash benefits result in German families more often employing their LIMCs on a purely informal basis. For German users with less private resources, this may be the only affordable option. In the Netherlands, this option is more or less precluded by the tight regulation of LTC cash benefits. However, users can opt, for example, for a cheaper placement agency to adapt the costs of the LIMC arrangement to what they are able and willing to pay. Family carers in both countries develop additional cost containment strategies in the day-to-day management of the care arrangement. They constantly make make-or-buy decisions; they try to 'stretch' their relative's cash benefit and they try to limit their use of private resources.

In both countries, full compliance with labour law regulations is hardly possible. Typical for LIMC arrangements is that the migrant carers are being paid on the basis of a 40 to 48 hours' working week while being on call more or less around the clock. Our findings indicate that family carers in both countries prefer not to reflect too much on the issue of what should count as working time, as it might make the arrangement unaffordable. In this respect, their

reasoning is similar to that of policymakers in countries with large informal LIMC sectors. This does not mean, however, that LIMCs do not have bargaining power vis-à-vis their (involuntary) employers. Most family carers see it as their first priority and responsibility to ensure that their relative gets good care, but this also makes them willing to invest (literally) in good relations with the LIMCs (on LIMCs' 'agency', see Bruquetas-Callejo 2019; Ignatzi 2014; Kniejska 2016).

Our findings show that at the country level, different levels of (regulation of) cash benefits translate into different employment modes, with different degrees of legality. At the level of individuals and families, different levels of financial resources translate into different abilities to reconcile affordability with other concerns and considerations. More extensive financial resources enable the users of LIMC arrangements to opt for a more law-compliant employment mode, to choose a placement agency that offers its LIMCs better working conditions, to hire better qualified LIMCs, and to purchase additional LTC services to relieve the LIMCs and/or the family carers themselves. By contrast, having limited financial resources may mean that other considerations have to be subordinated to affordability.

We conclude with a brief look at the future prospects of these transnational care arrangements. Both in Germany and the Netherlands, the demand for long-term elderly care will continue to increase in the coming years, and labour shortages in each country's LTC sector are expected to increase even more. Add to this the desire of more and more elderly people to stay in their own home, and the future for this type of care arrangement looks very bright. Nevertheless, it is important to also take into account developments at the European level and in the countries of origin of the LIMCs. In both Germany and the Netherlands, the development of a LIMC industry, although at a very different scale, has been facilitated by the EU free movement laws and the EU enlargement to Central and Eastern Europe. The vast majority of the LIMCs in Germany and the Netherlands are EU citizens from Poland and other 'new' CEE member states. However, only few of them have benefited from the EU free movement of workers regime. The free provision of services regime has played a more important role. Legal experts are questioning the legality of posting and self-employment constructions for this kind of work. Moreover, the European Economic and Social Committee, in an own-initiative opinion adopted in September 2016, recommended that live-in care work be recognised as a form of home care provision, that live-in care workers be entitled to similar protection as other care workers (including limits on working time and protection against bogus self-employment), and that the European Union monitor and improve the posting of live-in carers by applying the principle of equal pay for equal work.[9] These recommendations would increase the costs of LIMC arrangements to the extent of making them unaffordable for most of the current users. However, it is unlikely that the Committee's opinion will be followed. A development that is more likely to affect the future of the industry is the already emerging shortage of supply of labour in a few of the countries of origin, especially Poland. A survey conducted among LIMC placement agencies in Germany found that a large majority saw the limited supply of suitable care workers in CEE countries as the main challenge for the future (Petermann et al. 2016). It remains to be seen what will happen if the labour supply in EU member states dries up. It is conceivable that, on the one hand, it may lead to better bargaining positions and working conditions for EU citizens working as live-in carers, while

[9] Opinion of the European Economic and Social Committee on 'The rights of live-in care workers' (own-initiative opinion) (2016/C 487/02), OJ C 487, 28.12.2016. The Committee assumed that live-in care workers are present across all member states. Its opinion concerned migrants from third countries as well as EU citizens working in their home countries or abroad.

on the other hand, LIMC placement agencies may seek to set up recruitment structures in non-EU countries.

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