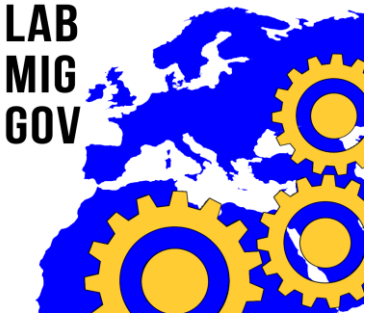

THE INTERNATIONALIZATION OF EUROPEAN CARE REGIMES

A CONCEPT PAPER

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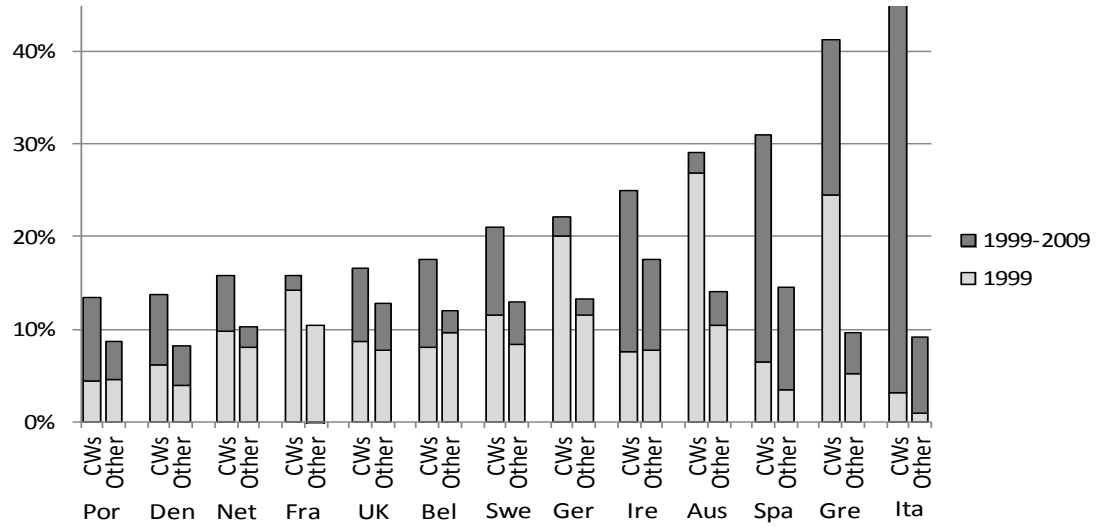
1. Introduction

The social, economic and labour market consequences of demographic ageing in Europe have been high in the agenda of the EU and of national policymakers in the years preceding the outburst of the economic crisis. They will arguably remain a major concern for European governments in the next years, the effects of the crisis notwithstanding. In particular, the sustainability of national care regimes face to increased care needs of an ageing workforce will represent one of the most serious challenges raised by demographic ageing, . The substantial growth of older cohorts, matched with increases in female employment and deep restructuring in shrinking welfare states, has produced a significant gap between the demand and supply of care, especially in the field of elderly care. First, the share of old age population over total population has been on the rise everywhere in Europe, although following a different pace across European countries: in 2010 the share of people aged 65 and over exceeded 20% in Germany and Italy and approached similar levels in Spain, Greece, Finland or Austria (OECD, 2011). At the same time, the pool of available family caregivers has been shrinking as a consequence of both demographic, socio-economic and cultural factors: decreasing fertility rates, changes in family structures and living arrangements, and, most importantly, a remarkable growth in labour market participation of women have jointly produced a crisis of traditional informal care systems, revolved around a central role of women within families in providing care to members in need. In such a context, European welfare states have undergone deep transformations in the last decades, under the pressure of budgetary constraints and neo-liberal principles of new public management: despite still substantial variation across European welfare systems, a convergence towards marketization of care services has been observed (Williams and Brennan, 2012). Care is now increasingly produced through market mechanisms and care labour markets have developed at the intersection of the public and private spheres.

Simultaneously, important labour shortages have affected labour markets in the care sector and migrant labour has substantially contributed to fill these shortages in most European countries, particularly in the field of elderly care. As the figure below tellingly shows, in the decade preceding the crisis, migrant workforce has been overrepresented in the total workforce of the long-term care sector, compared to other occupational sectors, in some of the core EU member states.

Figure 1: Foreign born share (%) of the long-term care workforce and other occupations in selected EU countries, 1999 and change 1999-2009



Source: courtesy of Alessio Cangiano, University of South Pacific; calculations based on the EU Labour Force Survey

In Mediterranean countries (with the exception of Portugal) the share of migrant workforce in long-term care has exceeded 30 per cent in 2009, with a dramatic increase observed in the preceding decade: in Italy migrant workers represented less than 5 per cent of the total workforce of the sector in 1999 while they raised to almost 50 per cent only ten years after. In other EU countries the weight of migrant care workers has remained at lower level, but still more significant than in all other occupational sectors. In UK, Sweden, Belgium, Ireland or Denmark the share of migrant

workforce in the care sector has doubled or more between 1999 and 2009, whereas in Germany, Austria or France the change has not been substantial.

Therefore, although the extent and forms of recourse to migrant labour in emerging care markets have been considerably varied across Europe, it is fair to say the European care regimes are going through a process of internationalization. A first partial explanation of this variation has certainly to do with the differentiated impact of population ageing across European countries: the different weights of old-age, working age and young-age population may create different needs in each country. However, as an emerging stream of research has effectively shown, this diversity finds its core explanation in the interconnection between care, employment and migration regimes in each individual country.

In this paper I aim at presenting and discussing the main concepts and theoretical accounts used to describe and explain the internationalization of European care regimes, as well as at highlighting existing research gaps and unanswered questions. I will draw on a variety of pieces of academic and non-academic literature recently developed by scholars of different backgrounds.

I will first analyse the emerging concept of care in the scholarly debate in its essential lines, with the goal of highlighting its multidimensional and complex nature, and make reference to the feminist scholarship that adopted care as a key concept for welfare state analysis, also in comparative perspective. I will then address the analytical description of care regimes, their main dimensions, existing typologies and recent converging trends in Europe, also highlighting how recent transformations occurred in European care systems have contributed to the expanding demand for migrant care labour (see section 3). In section 4 I will make reference to the emerging literature that has looked at the intersection between care, employment and migration regimes to explain existing care needs and available supply of (migrant) workers meeting those needs. Finally, in section 5, I will focus on the specific role of migration regimes in shaping characteristics of migrant (care) labour available and the structure of opportunities in which migrant workers act.

2. The emergence of "Care" as a key analytical concept for welfare states' analysis

In order to define our field of interest a first key conceptual clarification needed is related to the term *care* itself: what do we mean by care? What is (and what is not) care and which kind of activities does it involve? The scientific concept of care finds its origin in the feminist scholarship interested in defining the nature of the labour involved in caring for the others and "to analyse how this activity and the responsibility for it reinforced the disadvantaged position of women" (Daly and Lewis, 2000: 283). I will adopt here the definition proposed by Daly (2002: 252): "*Care [as I use it] refers to looking after those who cannot take care of themselves. It can be defined as the activities and relations involved in caring for the ill, elderly and dependent young*".

Given this broad and general definition, the concrete contents of the activities involved in caring are usually greatly variable since they usually encompasses a wide range of daily activities necessary to ensure both the physical and emotional wellbeing of dependent individuals. In particular care for elderly dependent people often implies both basic health or medical care and support in carrying out activities of daily living such as cleaning, cooking, washing clothes or shopping groceries. Furthermore, when provided in domestic settings by family or other (in)formal caregivers a clear-cut distinction between care to the dependent person and care of her living environment (i.e. domestic chores) is hardly attainable. Therefore, it is important to bear in mind the intrinsically multidimensional nature of care (Williams, 2010).

Care has recently become a key concept in comparative social policy analysis. Indeed, the notion of care and the ways through which it is provided has been developed in the framework of international comparative study of welfare states, starting from a feminist critique of the ground-breaking work of Gösta Esping-Andersen (1990) on the three worlds of capitalism (Duncan, 2000; Pfau-Effinger, 2005; Razavi, 2007). One of the main insights proposed by feminist scholars is that who should provide care, as well as how and where people are to be cared for are key questions in the understanding of welfare regimes and their answers are to be found in specific gender cultures and ideologies within a given society. Brigitte Pfau-Effinger (2005: 326) has proposed to analyse welfare regimes through the lens of what she defines as the "care arrangement", that is the "*interrelation between the cultural values about care, the relevant sense-constructions in a given*

society surrounding informal and formal care and the way institutions like the welfare state, the family, the labour market and the non-profit sector as well as social structures frame informal and formal care". The underlying idea here is that welfare states, and care policies within them, are highly gendered and their differences are strongly dependent on the way inequality structures, also based on cultural notions of gender, class and ethnicity, are articulated in any given society. By putting the spotlight on the gender dimension in welfare states arrangements, feminist scholars have contributed to identify care as a crucial element in welfare states theory. Daly and Lewis (2000: 285-286) have claimed the importance of (social) care as a key concept in analysis of welfare states and emphasised its multidimensional nature. They identified three main dimensions of care: first, "care as a form of labour", which draws attention to the conditions under which it is carried out; the second dimension locates care within a normative framework of obligation and responsibility, which helps to highlight the social and societal relations of care and the state's role in either weakening or strengthening existing norms about care; finally, they see care as an activity which involves costs, both financial and emotional, which extend across private/public boundaries.

3. Care regimes and their recent evolution

A thorough critical review of the existing literature on the comparative political economy of care and of welfare states goes beyond the scope (and the goals) of this short concept paper. What is instead important here is to better define, based on the existing literature, what is meant by care regime and how this interacts with other important policy regimes (primarily in the domain of employment and immigration) in determining the size and forms of migrant care labour in national contexts.

Drawing on the notion of "regime" used by Esping-Andersen (1990), Lutz (2008: 2) refers to care regimes as the "*organization and the corresponding cultural codes of social policy and social practice in which the relationship between social actors (State, labour markets and family) is*

articulated and negotiated".[1] A crucial aspect in this definition is the emphasis put on the different institutional arrangements underpinning the provision and organization of care in a specific national regime, differently biased towards three main social actors and institutions: families, State and markets. Some authors have complemented this triangle by adding up a fourth set of actors, variously defined as "community", "voluntary", "non-market" or "non-profit" sector and have portrayed the mix of actors and institutions involved in caring through the image of a (care) diamond (Razavi, 2007).

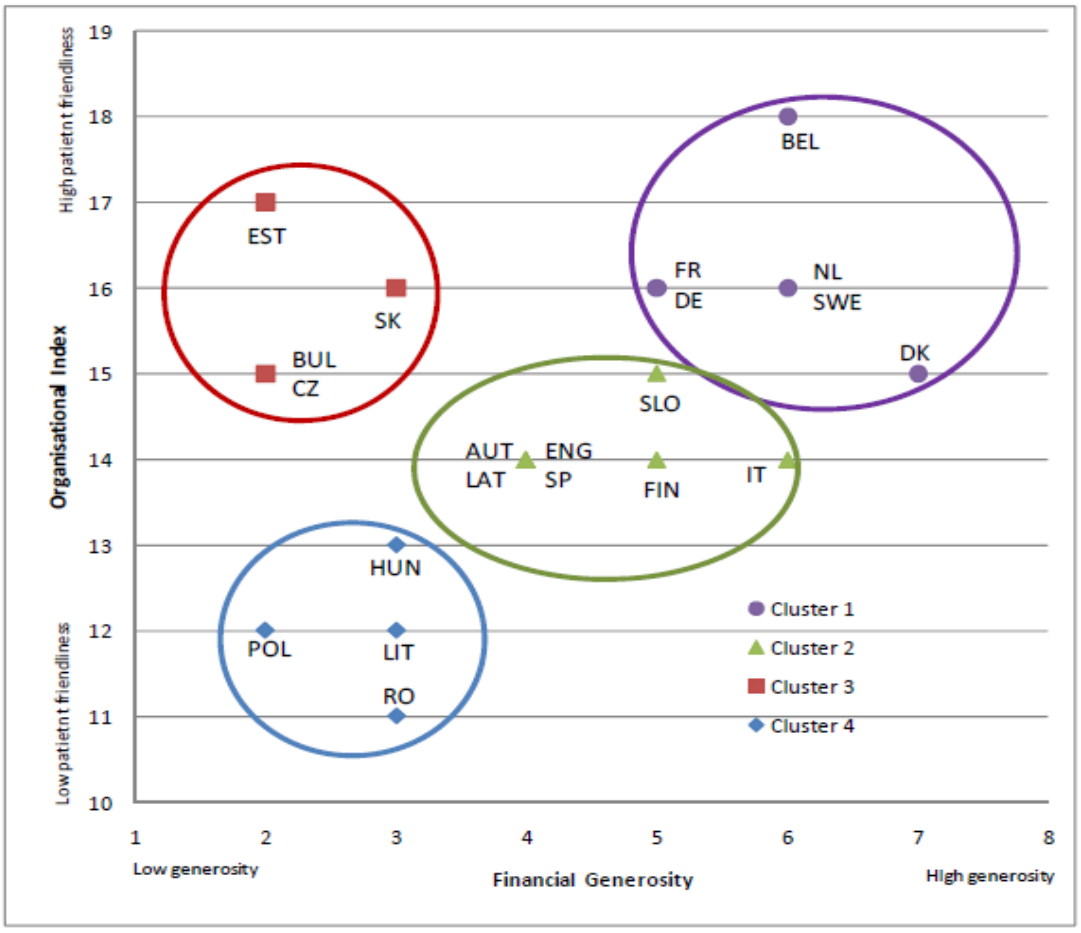
Beside the main actors/institutions involved in the organization and provision of care (*who* is responsible for caring?) other major interconnected dimensions of care regimes based on which differences emerge are: location, mode or funding of care. Within each dimension, variations are certainly not discrete but they rather emerge in continuums: thus when looking at location of care, concrete solutions may range from home-based care to residential care, both provided by either public or private organizations, or a mix of both). When looking at modes of care provision, we may find solutions that range from purely informal care provided by (female) family members, friends or acquaintances without any support from the state to formal care provided in public or private settings. Kraus et al. (2010) distinguish formal and informal care on the basis of the existence (or not) of a contractual relationship between the care recipient and the care giver: thus informal care is typically unpaid and associated with a pre-existing social relationship between the carer and the cared for whereas formal care is based on some kind of contractual relationship and the caregiver is remunerated. Finally, when looking at funding of care, various arrangements may be set up somewhere in between the two extremes of completely privately funded care, on the one hand, to state-funded care services on the other. Actual care regimes thus differentiate one to each other in the articulation of these different dimensions. Furthermore, the organization, funding and provision of care greatly vary according to the type of beneficiary, that is whether care is targeted for young children, disabled adults or elderly people. Finally, another key dimension of care regimes has to do with the way in which personal or social care interact and intersect with health care, especially when elderly care is considered. Social and health care may be more or less integrated in a comprehensive

[1] Williams (2012:371) uses the notion of "regimes" to "*denote clusters of policies, practices, legacies, discourses, social relations and forms of contestation that are relevant to the particular care/migration/employment regime*".

approach. And different conditions and regulations may concern a wide spectrum of occupations ranging to personal assistants to professional nurses.

Drawing on the literature on the variations in welfare states in the light of feminist scholarship on care, some authors have proposed various typologies of care regimes (See for instance Bettio and Plantenga (2004) Pfau-Effinger, 2005; Antonnen & Sipila, 1996; Lister et al., 2007). While most typologies target different domains of care,[2] Kraus et al. (2010) have proposed a typology of long-term care systems, which mostly address elderly dependent people (see figure 2 below).

Figure 2: Typology of Long-term Care systems in Europe:



Source: Kraus et. al, 2010.

[2] e.g. Bettio and Plantenga, 2004 targeting both childcare and elderly care or Anttonen and Sipilä, 1996 targeting "social care services" in general.

By drawing on two composite indexes of organizational depth and financial generosity, they clustered the 21 target countries of their study into 4 groups as showed in the figure below: a first cluster is composed by Scandinavian and Continental Europe countries (Belgium, France, Germany, Netherland, Sweden, Denmark) characterized by high organizational depth and financial generosity of their systems; at the opposite end, a second group is represented by Eastern European countries (Romania, Hungary and Poland) plus Lithuania, characterized by low organizational depth and fiscal generosity; the two intermediate groups features medium organizational depth and fiscal generosity (including here Italy, England, Spain, Finland, Slovenia, Austria and Latvia), on the one hand, and low fiscal generosity associated with high organizational depth (Estonia, Slovakia, Bulgaria and Czech Republic).

More recently, new pieces of research have instead highlighted "converging variations" of care regimes across Europe and beyond (Williams, 2012). Indeed, beside existing (and still substantial) variations related to specific contextual, institutional and cultural settings of care it has been observed that European care regimes are undergoing a process of convergence towards the commodification and consequent marketization of care (*See* Williams, 2010: 6; Ungerson, 2003).

Several factors may account for these transformations. On the one hand, public budgets constraints, are pushing towards a retrenchment of social policy expenditure. On the other hand new public management ideology[3] is putting pressure on care regimes to extend the care mix towards a greater role of market mechanisms in care provision and organization.[4] Furthermore, demographic and social factors are affecting the sustainability of state-funded care mechanisms: population ageing is rapidly increasing long-term care needs in a context where deep transformations of family structures (e.g. new living arrangements, increased number of dual-earner families, reduction in the potential number of care providers within families, etc.) are reducing the role of informal care traditionally

[3] In this respect, a lot of attention has been given to issues of choice and control by the care recipients on the type of care received . See in particular Shutes and Chiatti 2012 and Brennan, Cass et al. 2012.

[4] See the articles collected in the special issue of Journal of European Social Policy, 22, 2012

provided within families (particularly by women) and increasing the demand of care services provided in the market sphere.

As a consequence of these transformations a common trend observed in most European welfare state (and beyond[5]) sees the development of "routed wages" in care work (Ungerson, 2003), stimulated by the extensive use of so-called cash for care schemes that endow care users with a given amount of cash to be used to pay for their care needs. Different forms and degrees of conditionality are attached to cash transfer schemes, which may have, at their turns, different consequences in creating and shaping care markets (Da Roit et al. 2007, Simonazzi, 2009). One additional related consequence of these processes is the emphasis put on domiciliary, home-based care at the detriment of residential care (see Williams and Brennan, 2012; Colombo et al, 2011). It is exactly here that the boundaries between care work, restrictively meant as health and personal assistance to dependent individuals, and domestic work, broadly encompassing home-maintenance, domestic chores and care services is more blurred.

This new demand is opening new space for the employment of migrant workers in the care sector in many European countries.

4. Explaining the demand for migrant care workers at the intersection of care, employment and migration regimes

In the most recent years, starting from the observation of the increasing contribution of migrant workers in the care and domestic sectors of many European countries, the literature on care regimes has been complemented by specific attention given to the role of migration regimes in shaping the use of migrant labour in the provision of care (Lutz, 2008; Kilkey et al, 2010; Williams and Brennan, 2012). According to authors in this field of research, the patterns of migrant care labour are shaped by the specific intersection of care, (gendered) employment and migration regimes in each (cluster of) country. As Fiona Williams (2012: 364) effectively puts it: "variations in the employment of

[5] Problems related to demographic ageing and emerging care gaps seem to be relevant also in South-East Asia, as an emerging literature shows; see in particular: Ogawa, 2010; Huang et al, 2012; Michel and Peng, 2012.

migrant care labour emerge in the ways these three regimes intersect within any one country". In particular, the actual articulation of care and employment regimes in individual countries contributes to explain the emerging labour shortages (i.e. demand) in the care sector, and particularly in specific segments of the care labour market, while a deeper look into migration regimes contributes to account for the characteristics and patterns of labour market integration of the labour supply available. Nonetheless, despite a distinction between a demand explained by care and employment regimes and a supply provided through immigration policies is useful for heuristic purposes, it is nothing but a necessary simplification for analytical purposes. Indeed, demand and supply may also dynamically interact with each other.

The transformation occurred in most European care regimes towards the commodification of care through the shift from in-kind services to cash provision has set off the development of care markets. However, the outcomes of these policy developments in terms of labour market impact vary considerably according to country-specific organization of cash-for-care policy measures and especially on the degree of regulation (or lack of it) imposed on the recruitment and management of care labour (Ungerson, 2003). These latter aspects are indeed crucial in explaining emerging shortages in care labour markets. The regulation of care (and domestic) work related to skills and credentials, forms and conditions of employment, working conditions, social security entitlements, among else, greatly explain the attractiveness of this kind of work for native workers and consequently emerging shortages in the sector: native workers tend to shun those jobs with poorer employment and working conditions, lower wages, and bad social recognition. Consequently, as Geerts (2011) has showed using EU-LFS data for Germany, Netherlands and Spain, migrant workers are particularly concentrated in the lowest layers of the occupational ladder in the long-term-care workforce, while they are marginally represented among skilled professional care workers.

Indeed, as Simonazzi (2009: 216) has argued, specific care regimes "*differ in their capacities to create a care market, either social or private*". Drawing on comparative analysis of six European countries, she distinguishes between two groups of countries: one that rely mostly on in-kind provision, either directly or via contracting out, and with a greater reliance on conditional cash transfers (namely Sweden, UK and France) and the other that rely mostly on unconditional

allowances paid to the family carer or care recipient (Austria, Germany and Italy). In the first group a formal market for care is created whereas in the second informal care markets prevail (dualistic markets in DE and AU). Simonazzi describes "national employment models" in the care sector complementing characteristics of the care regimes with specific labour market regulations in the sector concerning especially pay and working conditions, forms of employment (i.e. dependent, self-employment or agency work) or skills, training and credentials. Thus, the combination of specific features of national care regimes and employment models explain the emerging gap between care labour needs and supply by native workers (i.e. demand for care labour) and, consequently, the modes of migrant involvement in the labour market. However, Simonazzi overlooks the role of the migration regime in explaining characteristics of migrant care workers in each country and their forms of employment.

Other authors have more effectively included immigration regimes in their comparative analysis. For instance, comparing UK, Italy and the Netherlands, Franca Van Hooren (2012) has identified three different models of migrant (elderly) care labour, originating from specific features of the national care regimes that shape the labour demand in the sector: Italy, where a "migrant-in-the-family" model of care has emerged (see Bettio, Simonazzi et al. 2006) as a consequence (among other factors) of the prevalence of unconditional cash allowances; UK, with a "migrant-in-the-market" model, related to the larger use of means-tested cash allowances and outsourcing of public domiciliary care services by local authorities to private service providers, and the Netherlands where none of the two has been observed and the employment of migrant workers in the care sector is still negligible. Van Hooren also looks at the role of immigration policies in setting up these three different models and she concludes that "*labour migration policies for care workers only had a limited impact on the employment of migrant workers" since "many migrants employed in the social care sector rely on residence permits unrelated to employment or [...] are already living in the country as irregular migrants*" (2012, p. 143).

In another study Shutes and Chiatti (2012), drawing on a comparison between elderly care systems in UK and Italy, reveal how trends towards marketization of care, although starting from two very different models, have converged towards a wide use of migrant labour in care services. In both

countries, though in rather different forms, marketization has lead to major shifts in the employment of care workforce from the public to the private sector where labour and employment conditions are poorer, and to an expansion of the care workforce directly employed by individuals and their families. The authors highlight the role of immigration policies in shaping the employment of migrant care workforce by creating the structure of opportunities and constraints into which migrant (care) workers act. Thus, migrants in an irregular status can only enter the informal labour markets where low wages and poor or exploitative working conditions are prevalent and, at the same time, holders of regular residence permits may face different sets of constraints and restrictions and, for instance, be bound to employment in a given sector/occupation or to a specific employer.

Williams (2012: 370-1) underlines the importance of looking at "*specific forms of migrant care labour that any individual care regime generates*": that is whether migrant labour is employed in elderly care or childcare, in (public/private) home-based services or in (public/private) residential care services, in the formal or informal sector, etc. The articulation of specific provisions and arrangements within each specific care regime contributes to explain the actual forms and conditions of employment in specific segments of the care sector and, consequently, emerging shortages in the care labour markets. Thus in general terms, a greater role of state-provided care services, either in institutional or domiciliary settings, usually entails better employment and working conditions (in terms of wages, employment protection, working hours, etc.), a greater labour supply by native (women) workers and a limited role of migrant labour. On the opposite side, the widespread use of cash transfers, with no or low conditionality upon their use, lower employment protection or poor regulation, creates strong incentives towards the irregular employment of care workers and make care work unattractive for native workers. Besides, the outsourcing of social care services to for-profit or not-for-profit providers by public authorities may result in low wages and poor working conditions for workers employed by care agencies and a lower native labour supply.

5. Explaining the supply of migrant care labour: the crucial role of immigration regimes

While the intersection of care and employment regimes in individual countries contributes to explain the emerging demand of migrant care workers (both in quantitative and qualitative terms) the

characteristics of the available supply of migrant care labour are better explained by immigration policies or regimes. Sainsbury (2006: 230) defines an immigration regime as a set of "*rules and norms that govern immigrants' possibilities to become a citizen, to acquire residence and work permits and to participate in economic, cultural and political life.*"

Indeed, the legal and migration status attributed to migrant workers by specific immigration policies significantly influences their labour market behaviour (see Cangiano, 2012). Immigration policies thus not only impact on the overall (quantitative) availability of migrant workers but: first, they, either explicitly or implicitly, select them on the basis of national origin, skill level, gender etc.; second, they affect the level of irregular migration, which may represent a significant supply of labour for the informal care markets (Ambrosini, 2013); third, they define the set of rights and entitlements that affect labour market behaviour of migrant workers after the initial admission (Sainsbury, 2006; Ruhs and Anderson, 2010). Immigration policies are thus a key component of the "opportunity structure" in which immigrants' agency develops.

Over the last few decades, legal avenues for the admission of migrant domestic and care workers have remained overall limited in most European countries. Some countries, namely Mediterranean countries characterized by familialistic welfare states, have adopted an active stance towards the import of care workers from abroad, either by opening up legal avenues for this category of workers (see ad hoc quotas in Italy or Spain) or by tolerating and subsequently regularizing irregular immigrant labour (Castagnone, Salis et al, 2013; Arango, Díaz-Gorfinkel et al., 2013). In Italy the domestic and care sector has rapidly become the main entry door into the national labour market and the first sector of employment for migrant women, even in the midst of the current economic crisis (Castagnone, Salis et al, 2013). Other countries have been quite open to the admission of care workers from abroad but with a much more selective approach, thus targeting only small numbers of skilled or highly skilled care workers, as it has been the case in UK or Germany (Cangiano and Shutes 2010; Lutz and Palenga-Möellenbeck, 2010, Laubenthal, 2012). However, as highlighted by Van Hooren (see *infra*), labour migration policies have only had a limited impact on the development of migrant care labour markets. Indeed, in most countries the largest pool of migrant care labour has been composed of what we have elsewhere defined as "functional equivalents" of

labour migration (Pastore and Salis, 2013), namely foreign workers admitted through channels different from labour admissions such as family, humanitarian or student migration or the free movement of European citizens (Spencer et al, 2010; Van Hooren, 2012). Indeed, in a number of countries, nationals of new EU member states in Eastern Europe have represented a significant contribution to labour supply in the care and domestic sector, often through some sort of "shuttle" or circular migration in neighbouring countries (Morokvasic, 2004). In Nordic countries and UK, although not politically nor legally framed as a form of migration, au pairs have represented an increasing supply of labour in the domestic and care sector in the last decade (see Isaksen, 2010 or Anderson, 2007).

Despite some relative opening in southern European countries, however, immigration policies across Europe have remained quite close to immigration of care workers, largely pictured as low skilled and therefore undesirable and useless: therefore, as Bridget Anderson (2011: 51) puts it, "*There [has been] an ostensible mismatch between immigration policies, which have taken little account of the implications of its emphasis on the 'highly skilled', and the demand for low waged, flexible workers from the social care sector.*" Nevertheless, the official restrictiveness towards immigration of care workers, has not certainly prevented the growth of migrant care labour in most European countries. In the vast majority of cases migrant care workers have entered through alternative migration channels or, quite often, they made large use of irregular avenues and overstaying.

The size of irregular migrants working as care workers, usually privately employed by households in home-based care, has been (and probably still is) massive in Mediterranean countries characterized by vast unsatisfied care needs. But also in other EU countries the phenomenon has not been negligible (Ambrosini, 2013; Tryandafillidou, 2013). For instance, Germany, which has kept until very recently a quite restrictive stance towards labour immigration (and low skilled immigration in particular), seems to have largely tolerated a sizeable pool of undocumented or irregular migrants working as home-based carers for the elderly, an attitude that Lutz and Palenga-Möellenbeck (2010) have defined of "complicity": an "open secret" to which the German governments have turned a blind eye. On the one hand, home-based care work, especially when carried out in live-in situations,

provides irregular migrant workers with key resources that allow them to cope with difficulties related to their irregular immigration status (Ambrosini, 2011). On the other hand, irregular status of migrant workers, or, alternatively, strong linkages between their labour and immigration status, is a key factor in explaining the demand for their labour by native households. Not only irregular migrants are more prone to accept badly paid and precarious jobs, but they are also particularly desirable for employers which hold additional means of control over them (Anderson, 2007).

Beside situations of full irregularity concerning the immigration status, widespread in southern European countries but less in others, another common condition depicting the employment of migrant care workers in Europe is that of semi-compliance (Ruhs and Anderson, 2010), that is "*the employment of migrants who are legally resident but working in violation of the employment restrictions attached to their immigration status*".

In the most recent years the scenario in labour migration governance across Europe has considerably changed as a consequence of the economic crisis and its differentiated impact in national labour markets (Pastore and Salis, 2013). Those countries that previously adopted more active labour import policies, namely Mediterranean countries and the Atlantic isles, have put the brakes to new admissions for the reason of employment, although Italy, with its two large-scale regularizations in the past four years, stands out as an outlier. Conversely, those countries less affected by rising unemployment such as Germany or Sweden, have instead adopted a more open approach, although still largely targeted around highly skilled immigration. However, latest data seem to show that in most European countries the care sector has remained overall less affected by the crisis observed in other occupational sectors, especially as migrant workers are concerned: in a general context of rising unemployment for migrant workers, employment of foreign-born workers in domestic or residential care services has increased respectively by 20 per cent and 44.5 per cent between 2008 and 2012 (OECD, 2013). If these trends will continue, although labour migration may represent only a partial solution to future shortages in the care labour market, we might expect important changes in the policies regulating the admission of care workers from abroad in the next years.

The internationalization of care regimes: future research perspectives

The sustainability of long-term care systems, particularly of elderly care systems, will represent one of the major challenges for European societies in the next future. Demographic trends towards population ageing will most probably continue, notwithstanding the long-term effects of the current economic crisis. As a consequence, labour shortages affecting care labour markets across Europe will remain significant, unless major changes in regulation and organization of care and employment policies will occur. Therefore, it is of key importance to deepen and widen the scholarly and public debate on how to tackle such challenges and on which role will international migration has and might have in the future in these processes.

Nevertheless, in order to understand if and in which direction the internationalization of European care regimes will continue, it is important to better understand the factors and processes that have determined and shaped it in the latest years. As I have tried to highlight above, a considerable amount of studies have addressed the issue disclosing the high level of complexity underlying such trends. Still, a number of key questions remain largely unanswered and need further investigation. At a first descriptive level, there is a surprising lack of comparative data on the employment of migrant workers in the elderly and long-term care sector across different forms of employment (i.e. direct employment by families, agency work, self-employment etc) or by specific working conditions (e.g. pay level, working hours, atypical forms of employment, etc.), also in comparison with native workers. Survey data such as those produced by the EUROSTAT Labour Force Surveys, despite a number of important shortcomings may help to fill this knowledge gap. Ad hoc-surveys may also be desirable.

In particular, I would here point out to two sets of research gaps concerning the role of immigration regimes in explaining the growing internationalization of care regimes and its country-specific configuration. Indeed, most scholars analyzing these issues have a background in comparative social policy studies and most of the studies carried out to date have focused more on the role of care (and employment) regimes while a well-focused analysis of immigration policies or regimes remain still lacking. In particular, issues related to the drivers of immigration policies related to care

migrant workers and to the impact of such policies on the immigration and employment patterns of migrant care workers remain under-researched.

Some key questions still need to be carefully addressed: what has determined the diversity of the policy solutions adopted in tackling labour shortages in the care labour markets? Why have some countries adopted a more active stance towards the import of migrant care labour from abroad whereas others have kept a more cautious or "hypocritical" approach, being closed to migration of care workers (generally framed as low-skilled) while tolerating different degrees of irregular migration and/or informal employment of migrant care workers? Different hypothesis may be advanced in this respect. A "functionalist" hypothesis could for instance be formulated: given the actual differences in extent of population ageing or general demographic transformations, and the actual configuration of the care and employment regimes, differences emerge in the size and characteristics of shortages/labour needs in the care sector which largely explain difference in immigration policies adopted; alternatively, a "cultural" explanation may be tested, related to the underlying cultural codes attached to care work, as reflected in actual care regimes, and the social acceptability of commodified care work, especially when provided by migrant workers; a further hypothesis could look more at the specific immigration regime in given countries and the characteristics of public debate developed around immigration issues: the openness or closure to immigration of care workers, typically framed as low-skilled, crucially depends on the prevalent orientations in each national regime towards highly skilled or low-skilled labour migration.

As for a second set of research questions that would deserve more attention, it would be important to look at how the different (care) migration regimes, possibly in combination with specific care and employment regimes, have affected patterns of labour market, and more in general, socio-economic integration of care migrant workers. Which different sets of opportunities and constraints have the different immigration regimes produced, concerning care/domestic workers? And how have care migrant workers themselves adapted to those opportunity structures? How the agency of migrant care workers have adapted to the different set of opportunities and constraints offered by each context?

Taking a more policy-oriented research approach, it could be worth exploring possible future scenarios of the international political economy of care. Indeed, the current economic crisis, with its differentiated impact on European economies and labour markets, as well as the effects that it will potentially have on the rethinking and redefinition of care, employment and immigration regimes, could considerably change the policy scenario. In particular it will be important to look at the role that functional alternatives to (care) labour migration, such as active ageing, active labour market policies addressing inactive or unemployed persons, or education reforms, will take up in the next years.

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