

Central and Eastern European countries in the migrant care chain

Introduction

Migration related to care is a phenomenon that has not been fully recognized in the context of public policy in Europe, and especially in Central and Eastern Europe. For decades, for political and economic reasons, Central and Eastern European Countries (CEEC) have been a “sending” ones in a global migration perspective. Accessing the EU in 2004 and opening borders to labour migration accompanied by rising demand for care in Northern, Western and Southern European countries stimulated migration of care providers from CEEC. In recent years however, also some CEEC – EU-members become an attractive destination country for migrants from poorer regions. Migrant care has its specifics: it is predominantly women activity, often undeclared, poorly or moderately paid. Typically migrants have lower economic and social status, do not enjoy equal social protection rights that domestic workers have and have lower minimum salary than domestic regulations require.

As population of CEEC is also ageing, care migration creates various tensions. Migration of younger cohorts, causes problems with assuring adequate informal care provision in home countries. Already today in some regions, with higher, long-term migration (e.g. Silesia region in Poland), scarcity of informal carers becomes a problem (Golinowska & Sowa 2018). Outflow of professional carers might result in shortages in professional employment in health and long-term care in the long run. Extensive, gender biased migration also increases the risk of family ties destruction.

Trends in care migration

Care migration in Europe is driven by several factors, most importantly by a growing demand for work in care professions in ageing societies of high income countries (Federal Ministry of Health 2013). In the light of demographic change in Western European countries shortages in nursing and care employment are reported that cannot be fulfilled with domestic staff, even if unemployment is observed. Domestic policies and measures aimed at increasing efficiency of care employment, re-training or increasing labour participation of women are insufficient to fulfil the demand for care. Recruiting personnel from third countries, especially from countries within the European Union (where labour mobility is supported by the freedom of workers’ movement, bilateral partnerships within the EU and recognition of formal qualifications of personnel) becomes an alternative.

Labour mobility opens doors for employing non-professional carers at homes, providing full-time care to older dependent people. The latter is in some countries (e.g. Italy Germany, Austria) supported with generous and unconditional cash benefits granted to older people with care needs (Simonazzi 2009, Fedyuk et al. 2014). More traditional perception of care duties and availability of cash transfers for care stimulates employment of low-salaried informal carers, which becomes available even for middle and low-income families (Simonazzi 2009). In result, an important, semi-regulated but politically and socially accepted segment of care is created (Roig 2014).

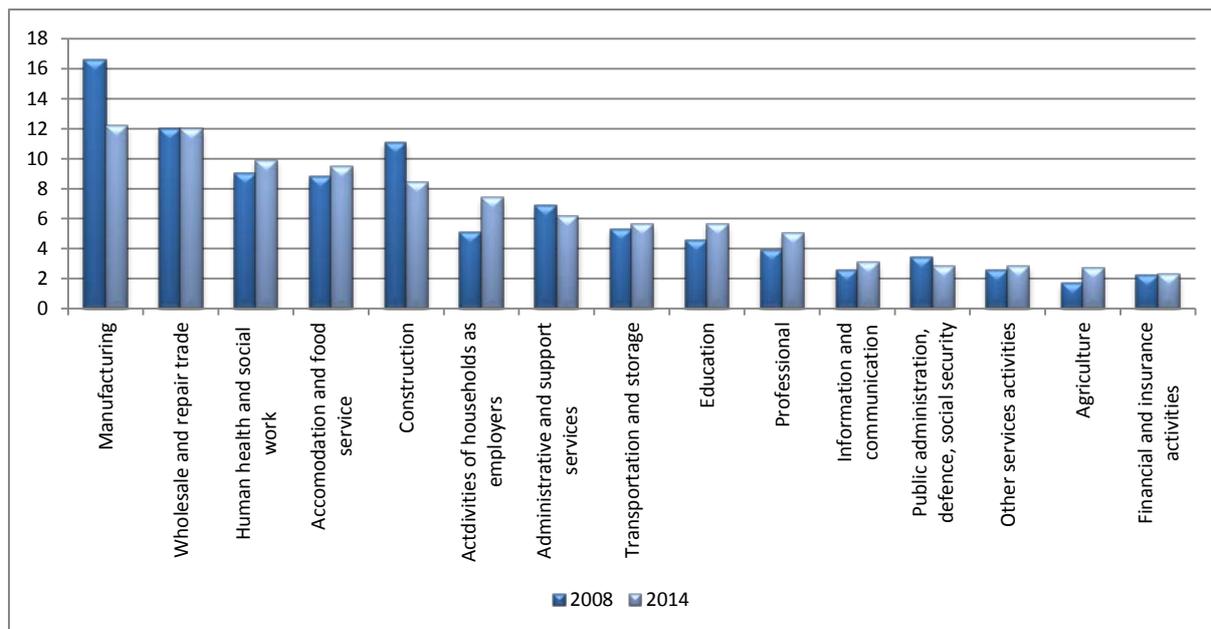
In Germany and Austria, semi-formal migrant care is provided in different forms: by local companies employing migrants on temporary contract (based on the rule of freedom of workers' movement), by an employer in the country of origin or by self-employed workers. Some countries undertake efforts to regulate migrant employment by recognizing it in domestic laws: Spain and Italy introduced such regulations in early 2000s and Austria in 2006/7. Austrian regulations aim at legalizing 24-hours migrant care, introducing minimal standards or care (regulating working time, living requirements for migrants, etc.) and assuring access to social security for migrant workers (Rodrigues et al. 2017). Although there is no clear evidence of improvement in the standards and quality of work in result of these regulations, scandals related to care provision seem to be avoided (Rodrigues et al. 2017).

In countries which are relying on marked cash transfers, in-kind services and contracting informal migrant services are of less importance. Formal services are more developed and provided either by domestic workers (Sweden, France) or migrant care workers formally employed in health and social services sector (United Kingdom).

On the supply side main factors contributing to migration are unsatisfactory working conditions and low earnings in health and care professions, high poverty levels, unemployment and inability to find a job in home country.

Overall, in the EU-28 health and social services are the main field of economic activity for almost 10% of first generation migrant workers (Graph 1). Another 7.4% of first generation migrants work in households and this share has strongly increased between 2008 and 2014. Households' work includes different types of activities, often in the grey zone of economy, related to household's keeping and care over children or older people.

Graph 1. First generation migrant care workers in the EU-28 by sector of employment



Source: EU Labour Force Survey 2008, 2014

The number of migrants from CEEC working in care services in countries of Northern, Western and Southern Europe is difficult to be estimated due to frequent non-registered, often temporary employment (shorter than a period required for registration). Thus employment in care remains an area un- or underreported in public statistics either of destination or in source countries. Registration of households' employment undertaken in several countries points to a high number of employed in domestic tasks – as many as 316 thousand workers in Italy (2002), 187.5 thousand workers in Spain (2005) and 60.6 thousand care workers in Austria (2017). Recent Austrian data show a high share of CEEC migrants among care workers with 56% of care workers coming from Slovakia and about 30% from Romania (Bauer 2017). Romanians also undertake work in care professions in Southern European countries: Italy and Spain. Since migrant care work is not registered in Germany and provided in different forms and on circular and temporary basis, it is more difficult to be estimated. The main group of migrant care providers comes from Poland, followed by migrant workers from the Czech Republic, Slovakia and Hungary. Estimates indicate various numbers of migrant care workers: from the overall 100 thousand CEE care workers to even 200-500 thousand Polish care workers in Germany (Roig 2014, Wiatr 2017).

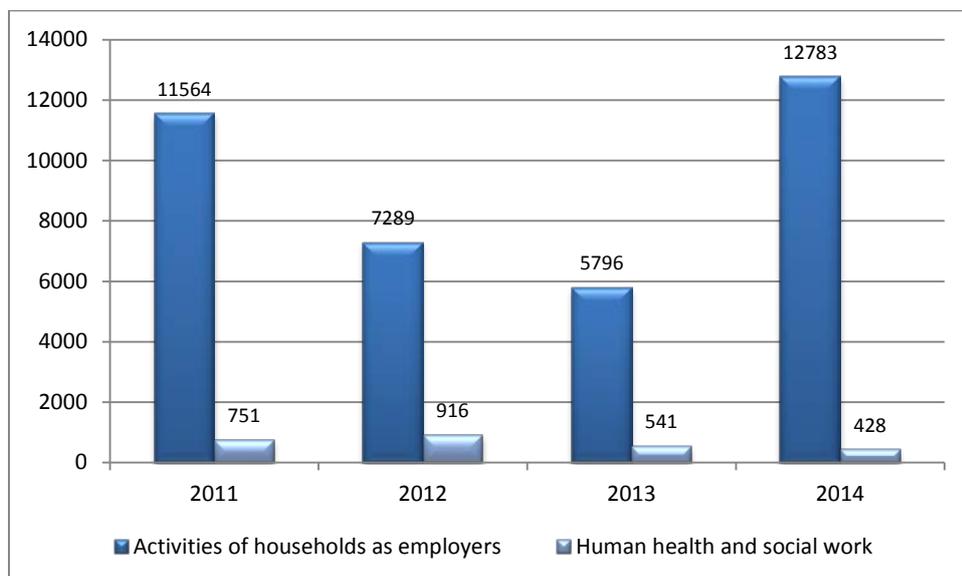
Dual status of CEEC in the care chain

Central and Eastern European countries are predominantly source countries, but some of them, enjoying higher incomes per capita and living standards (Poland, Czech Republic, Hungary, Slovenia), become a destination for carers from other, mostly non-EU countries such as Ukraine, Belarus or other former Soviet Union countries. Reasons for becoming a host country are to a some extent similar to Western European countries, including population ageing, changing family roles related to increasing labour market participation of women, changing life style of upper-middle class meaning not only involving in occupational activities, but also in more endeavour social activities and domination of smaller, nuclear

families. Other factors contributing to growing demand for care include economic migration of younger family members who typically are responsible for care within family, underdeveloped formal care services with cash benefits or services oriented primarily at assistance to the poorer disabled or older people. The latter often leaves middle or higher income families with little or temporary support from formal care institutions and makes them relying on services of expensive, but not always of best quality private market care institutions. In such circumstances employing a migrant carer at home becomes an interesting alternative. Since migrant care is highly unregulated and carers come from non-EU countries (Ukraine, but also other former Soviet Union countries, Serbia, etc.), this is typically employment in a grey zone of economy (Fedyuk et al. 2014). Migrants tend to work in turns – in case of non-EU citizens for as long as their visa permit allows – living with families and care recipients and providing full-time (24/7) services.

Due to geographical, historical and linguistic closure Poland has traditionally been a destination for migrants from Ukraine. Overall, Ukrainians constitute the greatest number of economic migrants in Poland registered with Polish authorities (Sobiesiak-Penszko 2015). Among circumstances that stimulate migrant workers from Ukraine are simple registration procedures (simplified in 2017) thanks to bilateral agreements, low wages, high unemployment and corruption in home country. Migration has also increased after the war in the Eastern Ukraine. Approximately every fifth migrant is engaged in domestic work: cleaning and/or care whilst a minor number of migrants finds employment in formal (especially residential) care settings. Public statistics indicate about 12 thousand migrants working in home-based care and less than 0.5 thousand employees in residential care (Graph 2). Still, an overwhelming majority of home care migrants is not registered with public authorities and works informally. The total number of migrants in Poland, including non-registered ones, is estimated at 100-150 thousands and seasonally even exceeding 600 thousand migrants (Sobiesiak-Penszko 2015).

Graph 2. Number of registered statements of migrant employment in households' activities and in human health and social work sector of economy in Poland



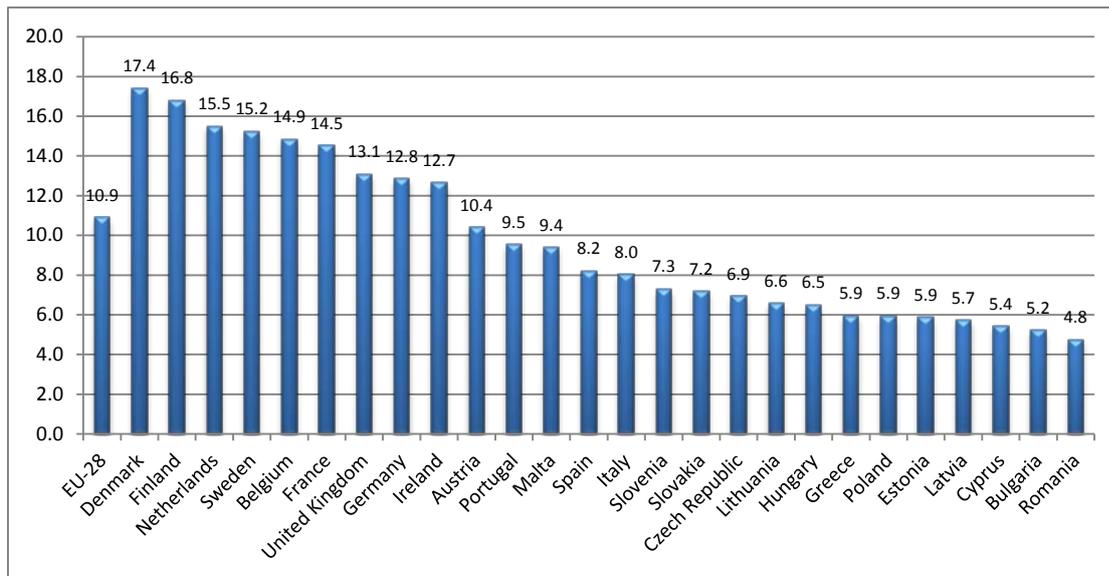
Source: Sobiesiak-Penszko 2015 after the Ministry of Family Labour and Social Policy

Other countries of CEE region also are increasingly becoming hosts for economic migrants, and among them care migrants. Czech Republic is experiencing inflow of migrants, particularly from Ukraine. Hungary, which has the most aged CEE population at the moment, reports growing number of care migrants from regions with Hungarian minority and historically close to Hungarian tradition, such as Romania, Ukraine and non-EU territories of former Yugoslavia (i.e. Voivodina). In 2010, mainly for political purposes, the Hungarian government granted dual citizenship to people with Hungarian roots living in other territories, which strongly stimulated migration (Lamura et al. 2014). Similarly, Romania granted dual citizenship to Romanian ethnicity citizens of Moldova resulting in over 94 thousand migrants from Moldova between 1991 and 2001 (Fedyuk et al. 2014). For them, Romania is becoming either a destination or transitory country if they are planning to move to another EU country. A large number of migrants in Romania is perceived as a potential to substitute outflow of women employed as care providers in Italy, Spain and the UK (Fedyuk et al. 2014).

Tensions caused by migration in sending countries

Care migration creates a number of serious ethical issues, economic and social problems in the sending countries. Ageing process and growing demand for care takes place in the region, whilst care needs of older people for a long time were not recognized as a social policy field and reflected in a comprehensive long-term care policy. Although formal long-term care is provided at home and in residential care facilities in the health and social sector, services reach only a small proportion (about 10-15%) of the dependent population, including older people (European Commission 2015). Many problems arise from lack of comprehensive or at least coordinated care system, including adequate funding of care in a two-tiers systems (health and social), accessibility of care adequate to needs, standardisation of care. Cash benefits are granted to dependent people themselves (e.g. in Poland) or their carers (e.g. in the Czech Republic), however being often insufficient to cover the actual care costs, they are a source of support for the family budget (Golinowska & Sowa-Kofta 2017, Georgieva 2016). There are also problems in assuring adequate employment in health and social work sector. The density of employment in health and social services, especially in Poland and Hungary, is among the lowest in the European countries (Schulz et al. 2013) and so is the share of employment in health and social work sector relative to total employment (Graph 3). It is well below the EU-28 average, amounting to less than 7% in most of CEEC.

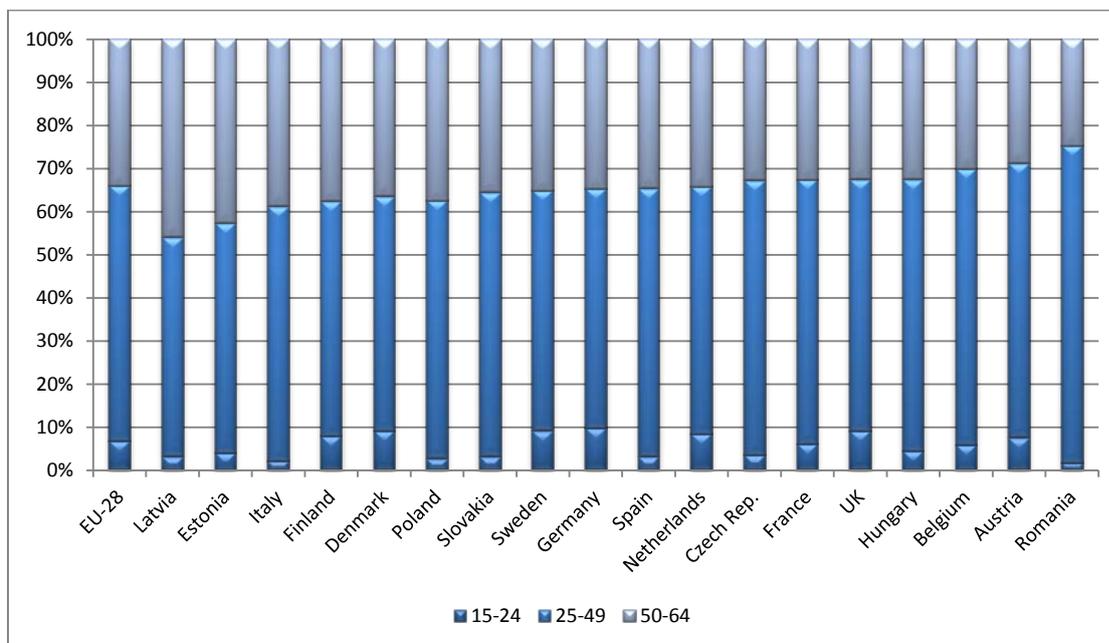
Graph 3. Share of employment in human health and social work in the total employment, 2013



Source: own calculations based on Eurostat, LFS [lfsa_egan2]

As the population ages, so are employees in health and social work. Among countries with the highest and increasing share of older workers (50-64) in health and social work sector are post-soviet countries of Eastern Europe (Latvia, Estonia), Poland and Slovakia (Graph 4). Ageing of the population is related to poor attractiveness of professions in health and social work sector, where earnings and prestige of employment are low accompanied by high level of responsibility and numerous obligations.

Graph 4. Structure of employment in human health and social work in selected EU countries



Source: own calculations based on Eurostat LFS data [lfsa_egan2]

Given these trends, migration additionally drains the nursing and care workforce. Statistics of the National Chamber of Nurses and Midwives (*Naczelna Izba Pielęgniarek i*

Położnych) in Poland indicate that annually about 1 thousand confirmations of qualification necessary to undertake job in other EU country is issued; overall in the years 2004-2016 the number of documents issued exceeded 19.9 thousand (NIPiP 2017). It is impossible to state however how many of these professionals actually migrated to gain employment in care profession abroad. To contain outflow of workforce and losses related to high costs of medical education, Hungary adopted regulation obliging students in publicly funded education to work domestically for a certain period after graduation (Lamura et. al 2014).

Outflow of carers, mostly women, causes tensions and social problems on the domestic labour market and within families. In Central and Eastern European care in older age is traditionally a family domain, what is strongly supported by a conservative perception of traditional female role in the family and social expectations. Care responsibilities often result in withdrawal of women in their 50s and 60s from the labour market, especially in cases of high care intensity. Studies undertaken in Poland point that low employment rate of females (accounting to 37.6% in 2016 for women aged 55-64), is related to low retirement age and caring responsibilities (Kotowska et al. 2007; Łuczak 2017; Saczuk et al. 2016). Care migration impacts outflow of women from the domestic labour market as well.

Since carers are working abroad and on average for higher remuneration that they would be offered on domestic labour markets, migrants' families are often better-off financially, but socially deprived (Lamura 2010). Families are experiencing problems with limited assistance to older people in need or children. In fact, older people themselves often have to undertake family responsibilities of migrant mothers.

Care, gender, de-qualification and the risk of exclusion

Care profession is strongly gender biased. Migrant care providers are typically women in their 40s, 50s or 60s, who often decide to migrate when job they home duties are less sound - when their children are grown up and before their parents become dependent (Wiatr 2017, Bauer 2017). If younger mother decides to migrate, their closest ones (typically grandmothers) have to take over the role of bringing children up. Women have complex motivation to leave their families and take up a job abroad. Economic reasons are important, including unemployment, low earnings, and poverty vulnerability. But social reasons are also of importance. Women often decide to migrate when they find themselves in a rut, when their former commitments (i.e. marital) are in crisis. Non-fiction reportage based on interviews with migrant Polish carers working in Germany shows that at a very high cost of emotional distress, social isolation and deprivation of own needs, with full-time readiness to work and moonlight services, women gain financial independence, become breadwinners for their families and in some cases rebuilt their self-esteem thanks to being able to cope in a new environment and redefining their life goals (Wiatr 2017). Higher earnings often allow them to pay off undertaken loans or build houses for their families.

Care work, especially at dependent's home, is typically a low-qualification job. Thanks to this feature the sector easily absorbs migrants, but at the same time it might lead to de-qualification of workers. Study of migrant workers from Ukraine employed by households

in Poland shows that carers are often teachers, nurses or students who want to gain additional income (Sobiesiak-Penszko 2015). In many cases migrants begin their household employment as cleaners and then become carers.

Most of migrant carers is either unemployed in their home country or quits job in their home country. But some of them, mainly nurses, take a job-leave for the period of 2 months to undertake better paid migrant care work, and after that period return to their home country and domestic job. Employment in care is typically a short-term activity and often without any labour protection, often undertaken in the grey-zone, without any formalized contract. Even if the job is formally recognized, contracts are typically temporary with earnings below minimum salary at the destination country and minimal (if any) coverage with social protection schemes (Wiatr 2017). This often leaves migrant carers without entitlement to health and other social protection schemes both: in their home and destination country.

Conclusions

Migrant care work is growing in importance responding to the raising care needs throughout Europe. Migration of care providers from Central and Eastern Europe is related the demand in destination countries and weaknesses of the economic transformation that source countries have been experiencing over the past decades. Poverty and unemployment in poorer regions are among major reasons for economic migration, also in relation to care. Lack of investments in health and social sector employment stimulate professional workforce migration might result in a workforce drain. Additionally, migration was stipulated by the EU accession and free labour movement based on bilateral agreements.

At the same time the CEE region is demographically changing with steep increase in the number of older dependent people in the years to come. The question is, whether with underdeveloped formal care institutions and limitations in provision of informal care related to changing female role, labour market participation and migration of potential care providers CEEC will be able to meet needs of older people. Slowly changing position of some CEEC in the migration chain, which become not only source, but also destination countries might mitigate drawbacks of the insufficient long-term care provision. At the same attention should be given to countries which are only sending ones, such as Ukraine or Moldova, to minimize negative effects of labour force drain.

Given these changes, there is a need to recognize migration as a source of care provision in destination countries, including CEEC. Regulations that have already been introduced in some countries, leading to formal recognition of migrant work, improvement in working conditions of migrant care providers, assuring equal rights with domestic care and access to social protection are needed. Investments in trainings and increasing quality of migrant care would also be of advantage. Migrant work, if related to higher earnings might be less competitive then, but respecting human and social rights of migrant care providers becomes a necessity.

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