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THE SOCIAL CONSTRUCTION OF MIGRANT CARE WORK

At the intersection of care, migration and gender

Amelita King-Dejardin



Gender,
Equality
and Diversity
& ILOAIDS
Branch

Labour
Migration
Branch

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AMELITA KING-DEJARDIN

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PREFACE

Care work, both paid and unpaid, is of vital importance to the world of work. Women and girls are performing more than three-quarters of the total amount of unpaid care work. Demographic, socio-economic and environmental transformations are also increasing the demand for care workers, who are often international migrants working as domestic workers, child-minders, nurses or doctors.

Across regions, sectors and occupations, migrant care workers are mainly women engaged by private households, in informal settings, working in the informal economy without full access to social protection and basic labour rights. Often, they migrate under temporary migration schemes, leaving their own families behind in the care of other family members or of other domestic workers, creating what is known as “global care chains”. They provide essential care services to young and older persons, or to persons with disabilities or health concerns. However, because of the asymmetries between countries of origin and destination and often inconsistent law and policy on migration and care, working conditions of migrant care workers tend to differ to a greater or lesser extent from those of their national counterparts.

Since paid care work will remain an important future source of employment, especially for women, the future of migrant care work is crucial to achieving equal and decent working conditions for all women. The working paper *The social construction of migrant care work* examines the implications of migration in the care economy and its effects on women’s empowerment and gender equality. Looking at issues related to the gendered division of labour, this paper challenges the traditional ideologies of care, and provides a framework to understand the way care responsibilities are being reallocated between families, households and the State, as well as among countries with different levels of socioeconomic development. At the same time, the paper calls for action and highlights the need for effective policies to help improve the governance of labour migration for health-care workers, address decent work deficits for better recruitment and retention and improve skills recognition and certification.

The social construction of migrant care work is part of a series of working papers that was commissioned as background research for the major ILO report *Care work and care jobs for the future of decent work*. This major report and related research build a compelling and evidence-based case for placing good quality care work as a priority in macroeconomic, social protection, labour and migration policies agendas. These publications represent an important contribution to the ILO’s Women at work centenary initiative, which has been examining why progress in closing the gender gaps in the world of work has been so slow and what needs to be done for real transformation. It has also been identifying innovative action to guide work on gender equality and non-discrimination as the ILO enters its second centenary.

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1

INTRODUCTION

1.1. BACKGROUND AND RATIONALE

Paid care workers, those who look after the physical, psychological, emotional and development needs of other people – doctors, nurses, teachers, early childhood educators, older person caregivers, therapists, nannies, household cooks and many others – comprise a large and growing segment of the labour force in developed and developing countries. They work in diverse situations: in educational and health institutions, both public and private, as well as in private homes; in formal and informal employment arrangements, with clear or fuzzy contractual conditions; in situations where employers may be government agencies, private enterprises, non-profit organizations and private households.

There is a long history of wealthy and urban households relying on and recruiting migrants from rural, less developed or poorer areas of the country to provide them with household and personal services as paid employees (Sarti, 2008, pp. 77–97). However, the most striking development of the past two to three decades is the growth, in magnitude and significance, of international migrant care workers (Yeates, 2017; Yeates, 2005). Substantial numbers of migrant men and women (but with the overwhelming majority being women) from across national and continental borders are supplementing the unpaid care work and paid care labour of non-migrant women in higher-income and more developed countries to meet the latter’s expanding care needs and care labour shortages. In response, many developing countries have pursued strategies to produce and “export” care labour, while some developed countries have actively recruited overseas workers for their care workforce.

An international division of care labour has thus emerged – one in which care services in developed and better-off countries are increasingly carried out by women and men from less developed, low-income or less wealthy countries (Yeates, 2005, pp. 3-5). Migrant workers are employed in a wide range of care jobs of varying skill levels (including health professionals employed as care aides, and teachers and midwives as domestic workers), from home-based care and domestic work to institution-based care. They have diverse profiles and take different migration pathways from countries of origin to destination. Many had been care professionals and care practitioners (e.g. doctors, nurses, therapists, teachers, older person caregivers and domestic workers) in their home countries, while many had never worked, or trained, as care workers. Some, such as asylum seekers, students, tourists and holiday-makers, and nationals who have a right to “free movement” between countries within a regional community (e.g. the European Union (EU) and the Southern Common Market (MERCOSUR)), had no intention of working in paid care services when they immigrated.

Five issues of care-labour migration motivate this report. First, in spite of the primordial importance of care to human survival and development, care workers tend to be “undervalued, under-appreciated and under-paid” compared to other workers (Razavi and Staab, 2017; Williams, 2012; England et al.,

2002; Daly, 2001). This tendency has been traced primarily to the fact that societies generally equate care work to women's work and "inherent" gender role in societies, which are regarded as low-skilled (not requiring training) and "unproductive" (unlike paid work), and in many situations quite physically laborious (e.g. housework). Because of care work's low social status and low pay, workers providing home-based personal and household services have often come from less well-off kinship relations or from socially disadvantaged, poorer communities within the country. International migrant care workers thus embody two, or even three, social identities that put them at a greater disadvantage in host countries than non-migrant care workers and other nationals. In addition to being care workers and being overwhelmingly women, they are of a different race, ethnicity or nationality, and often from a less developed, less wealthy country (thus belonging to a lower economic class). In addition, they have an immigrant status that confers (or withholds) certain legal labour, economic and political rights in the country of destination, and differentiates them from non-migrants. The inequalities of gender, race, ethnicity or nationality, class and immigration status are thus intertwined and embedded in migrant care labour and in the migration trajectories of care workers.

Second, following from the above, the presence and employment situation of international migrant workers in care provisioning are shaped by three principal regimes in the countries of destination: the care regime and the assumed gender division of caring roles; the migration regime and how care migrant workers are treated within that regime; and the labour market or employment regime and whether this treats care workers and migrant workers equally or unequally compared to other workers. One therefore asks, why is it that migrant care labour has become significant to the provision of care in certain contexts but not in others? In what ways do elements of these regimes differ and interact to create the varying roles and positions of migrant workers in providing care services across countries? While those who need care (families and individuals) will surely have their personal preferences, the range, accessibility and cost of available types of care providers matter.

Third, because of its interpersonal character, care is highly labour intensive, and thus a relatively costly endeavour. It would be quite difficult to enhance its productivity through mechanization and technological innovation, or through economies of scale. Therefore, in the face of resource and budget constraints, economic crises and declines, care suffers. Both care workers and care recipients may pay the price in terms of low wages for care workers, high prices for care services, and/or low-quality care (Folbre, 2006). In addition, those who need care most, i.e., young children, older persons and those who are chronically sick, generally do not have funds of their own to pay for care, and thus depend on others – their families, community or the state – to pay for their care (England et al., 2002). But the latter do not necessarily have the capacity or the willingness to do so. These points are particularly relevant because of the predominance of political agendas advocating for leaner public spending and social spending cuts, the low coverage of social insurance and the already lower valuation of care work. The immigrant status of care workers may put them at an even greater disadvantage than native care workers.

Fourth, the process of care involves not only the care recipient, but also the caregiver. Both are indispensable in ensuring people's access to quality care. Care recipients, their families or care users, often workers with care responsibilities, and care workers actually share a "common interest" in finding socially optimal care solutions and arrangements that maintain the quality of care as well as respect for care workers' rights (Daly and Standing, 2001; Folbre, 2006). The conditions under which care workers are employed and discharge their functions are often disassociated from the quality of care. Notions that care work is altruistic reinforce the primacy of the needs of care recipients. At the same time, there are "third parties" to the care recipient–care worker relationship – employment agencies that recruit, train and deploy care workers, formal and informal recruiters that direct the transnational movements of migrant workers and agencies or establishments that directly employ

care workers and manage the delivery of care services to individuals and private households; they all have a critical role in shaping the care relationship, the working environment of care workers and the quality of care.

Finally, the future of migrant care labour has important implications for the future of women's work and for gender equality in the twenty-first century. The demands for care in developed and developing countries are rapidly increasing in scale and range, not only because of population growth but also due to ageing populations who are living longer, rising human and social development standards and preferences, stronger pressures on women to actively engage in the paid labour market, changing family structures and the requirements of expanding, modernizing economies. Yet, families across the world continue to depend on the unpaid care work of family members, kin and friends, who are mostly women, for the bulk of their care needs in spite of the rise of public care support and private care provision. How will the expansion in the employment of migrant care workers impact on the gender division of labour between unpaid care work and remunerative employment?¹ As long as unpaid care work is unequally shared between women and men, women will be in a disadvantaged position in the labour market. Are contemporary care regimes pointing towards narrower inequalities in care obligations and more freedom of choice between the sexes? At the same time, the growth in demand for care is creating new employment opportunities in care economies, which are still women-dominated. Do these new opportunities offer a better position for women in the labour market? Will this lead to a fairer valuation of care work and women's work?

1.2. FOCUS AND AIMS OF THE PAPER

This report will look into the interconnections between care work, international migrant labour and gender relations in light of the issues mentioned above. Specific attention will be given to the following issues: the migration patterns, characteristics and working conditions of women and men migrants in care economies of destination countries; how these are related to the destinations' normative and institutional contexts of care, international migration, and labour and employment rights of care workers and immigrants; the implications of female and male migration in the care economy on the position of women and gender equality; and areas for action.

There are myriad aspects and issues regarding the interconnections between migration, gender relations and the care economy. There are also many types of care services and many categories of care workers. This paper cannot feasibly tackle all of these, not even many of them.

This report is focused on the situation of migrant care workers in destination countries. To understand the interconnections of care, migration and gender, it will look closely at the situation of the particular group of migrant care workers who look after dependent members of the family (older persons and young children) and who provide care services to private households. There are three reasons for this special focus. First, the work of this group of migrant care workers reflects the process through which care work is shifting from unpaid care work in the family to paid work outside the family, and through which the responsibility for care provisioning is being reallocated between the family, the State and the private sector (both for-profit and non-profit). This is useful in understanding why and in which contexts migrant labour has become significant in care delivery. Second, the work of this group of care workers touches the core of the gender division of labour and thus of gender relations and equality. This would help to clarify whether or how paid migrant care labour may be reshaping the gender ideology of care. Finally, the policy and institutional contexts of this group of migrant care workers are relatively better studied than those of other care workers (e.g. health professionals

¹ See Lewis, 2001, who deals directly with this particular question.

employed in hospitals and teachers in schools and universities). As a last point about this paper's focus, it is noted that the relations between care recipients and care providers or caregivers are highly complex – personal and relational, and social as well as economic and political. This report, however, focuses more closely on the policy connections between care, migration and employment, and their implications for the position and working conditions of migrant care workers.

The impact of the emigration of care workers on their countries of origin is one major subject that will not be tackled in this paper. Annex 1, however, offers a glimpse of the implications for countries of origin.

1.3. STRUCTURE OF THE REPORT

Section 2 gives an overview of the international migration of care workers. Data about the migration of care workers are scarce and patchy. Nonetheless, available global data and snapshots of country- and region-specific situations give a sense of the scale of the presence of migrant workers in care provision, their principal destinations and countries of origin and the rising demand for their services.

With the international overview as backdrop, section 3 presents a conceptual framework for understanding care provision and the role of migrant labour – in addition to the basic concepts of care, it details the principal actors involved, the socio-economic and normative context of care, the underlying gender code and the interconnections that shape care structures and delivery. Given this framework, the forces that drive and shape the role of migrant care labour are highlighted.

The subject of section 4 is the employment situation and working conditions of migrant care workers providing older person care, childcare and/or care to private households (labelled in this paper for brevity as “family and household care” to differentiate it from purely older person care or childcare) in destination countries. The reasons for this focus were given above. Building off the conceptual framework presented in section 3, subsection 4.1 presents a few selected country cases across three ideal types of care regime; namely, the familial care model, public care services model and market-based, means-tested care model, and the differing migration policy approaches to the entry of foreign workers. The analysis focuses on how older person care, childcare or family care is delivered, the location and role of migrant workers in care provision and their working conditions, and how these are linked to the care, migration and employment regimes. To the extent possible given the available data and statistics, the situation of migrant care workers is compared with that of non-migrant workers and disaggregated by sex. Subsection 4.2, drawing from the country cases and secondary literature, summarizes and highlights the main issues relating to the employment patterns and working conditions of migrant older person care providers, childcare and family care workers, and their position in the care economies of destination countries. The section pays special attention to the question of whether male and female migrant care workers are concentrated in specific segments of the care economy, and trapped in poor-quality jobs.

Section 5 focuses on areas for action aimed at addressing issues related to the quality of care jobs and the employment situation of migrant care workers. Specifically, it reviews major actions taken by key actors at international and national levels, and highlights some of their positive aspects as well as gaps and pending challenges that need to be addressed by future actions. Mindful that the quality of care depends on the needs of both care recipient and care worker, the section tries to highlight good practices that respond to the interests of care recipients as well as care workers and enhance the positive role of third parties in this care relationship. Section 5 ends with some proposed areas for further action.

2

THE INTERNATIONAL MIGRATION OF CARE WORKERS: AN OVERVIEW

This section provides an overview of the broad trends and patterns of international migration of care workers, as well as skilled and less-skilled persons who migrate and end up in care jobs in destination countries. It is important to bear in mind that systematic data on international migration are scarce and patchy, and subject to many limitations. Subsection 2.1 details the limitations of international migration data and the data sources used by this paper to provide a global picture. Because of the significant geographical asymmetry in available migration statistics, section 2 looks at the global scale of migration from the perspective of destination countries (e.g. extent of presence of foreign-born in host countries rather than emigration), and may appear OECD-centric. Efforts have been made to present information on non-OECD destination countries and subregions. Subsection 2.2 presents broad trends in international labour migration and subsection 2.3 focuses on trends with regard to the migration of high-skilled and less-skilled workers. These trends are relevant to this paper's topic because, first, care-specific labour migration programmes are relatively scarce in the world, in that migratory movements of care workers and potential care workers are usually embedded in general migration streams; and, second, the admission policies of most high-income destinations increasingly favour high-skilled over less-skilled migrants. Subsections 2.4 and 2.5 focus on specific categories of care workers for which data are available: teaching and health-care professionals, and workers who provide care services directly to persons in their homes or to private households, respectively. Finally, subsection 2.6 briefly discusses the factors that push and pull care workers to leave their home countries and live and/or work in other countries.

2.1. A FEW WORDS ON INTERNATIONAL MIGRATION DATA

2.1.1. DATA LIMITATIONS

Data on the international migratory movements of care workers, as well as of migrant workers who end up as care workers in their country of destination, suffer from various limitations and are not always comparable (ILO, 2015a, pp. 25–28, 37–40; Caravatti et al., 2014, p. 18; Aluttis et al., 2014; WHO, 2006). First of all, many countries, particularly in less-developed regions, lack or have limited, sometimes unreliable, empirical demographic information. Second, available national population censuses and labour force surveys, from which migration statistics are derived or estimated, use different statistical definitions and criteria for identifying an international migrant. Among several methodological issues, migrants may be identified by their country of birth (i.e. migrants are defined as foreign-born), or by their citizenship (i.e. migrants are defined as foreign citizens, and foreign-

born who have acquired the nationality of their country of residence would be excluded from the migrant population). Differences in the concept of “residence” are also crucial.² Depending on the minimum period of residence required to be classified as an international migrant, the statistics may exclude certain contemporary types of temporary foreign workers who stay only a few months at a time in the destination country, such as seasonal farm workers, “posted” workers and “holiday workers” (discussed further below). Refugees and asylum seekers may be covered by censuses in countries that have granted them refugee status and integrated them but may be excluded in countries where refugees have no freedom of movement and are segregated in camps. In some cases, migrant statistics use proxy indicators, such as possession of a temporary visa or a work permit.

The United Nations (UN) Population Division estimates the stock of international migrants, who are defined as persons who are living in a country other than their country of birth (UN DESA, 2016a). The foreign-born criterion is given preference whenever national records give place of birth, and where this is not available, data on foreign citizens are used.³

A third important limitation affecting migration data is that there is yet no internationally agreed definition of “migrant worker”. The ILO Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143), in its Part II, defines a migrant worker as “a person who migrates or who has migrated from one country to another with a view to being employed otherwise than on his own account and includes any person regularly admitted as a migrant worker”.⁴ This definition excludes, students, trainees, and employees of organizations in a country who have entered that country temporarily for an assignment and will (or should) leave on completion.⁵ In practice, however, most data sources are unable to take account of the reasons for migration (ILO, 2015a, p. 31). Moreover, migrants who had no intention of being employed may end up working anyway in the country of destination, and students, trainees and others who do not have the legal right to engage in economic activities in the host country may find work, albeit in irregular conditions. The most recent ILO global estimates of migrant workers take a more inclusive view than the Migration for Employment Convention (Revised), 1949 (No. 97) and Convention No. 143, and define “migrant workers” as international migrants (as defined by the UN Population Division) who are “currently employed or seeking employment in their country of current usual residence” (ILO, 2015a, p. 28). It is also worth noting that the 19th International Conference of Labour Statisticians (ICLS) Resolution concerning statistics of work, employment and labour underutilization has adopted an inclusive concept of work: “Any activity performed by persons of any sex and age to produce goods or to provide services for use by others or for own use” (ICLS 2013). This concept of work includes migrant workers engaged in own-account work – also excluded by definition from the scope of Convention No. 97 and Part II (equality of opportunity and treatment) of Convention No. 143. It also includes trainees.

A fourth limitation is that international migration data rarely provide migrants’ occupation in their country of origin or of destination. Furthermore, most countries do not track, or track only poorly, health and education professionals and other care workers entering their workforces, and few countries have any data at all tracking those leaving the country (Caravatti et al., 2014, p. 4). For the select

² There are two concepts of residence. De jure residence implies having a place of abode in a country and acquiring certain benefits and obligations but without necessarily implying actual physical presence in the country at any period of time, while de facto residence implies actually living or being present in the country for more than a minimum length of time, which varies from country to country (ILO, 2015a, p. 28).

³ For the data presented in the UN *International Migration Report*, data on the foreign-born were available for 188 of 232 countries and areas included in the analysis (81 per cent). Foreign citizenship was used for 44 countries (19 per cent) (UN DESA, 2016a).

⁴ Article 11(a).

⁵ Also excluded are “frontier workers”, “members of liberal professions and artistes” and seafarers, which were excluded from the definition of migrant for employment set out in Article 11(2) of the Migration for Employment Convention (Revised), 1949 (No. 97).

number of countries that track migration of health-care workers, available information is generally limited to registered doctors and nurses. Data on movements of pharmacists, occupational therapists and many other types of health workers are virtually non-existent (WHO, 2006, p. 98). These gaps make it extremely difficult to establish the scale of international migration of care workers.

As a final point, undocumented migrants and migrant workers in an irregular situation, i.e., those who have entered intending to stay in the country concerned without fully satisfying the conditions and requirements set by that country for entry, residence or exercise of an economic activity may not be recorded by population censuses, registers and household surveys. Because employment within private households can easily be concealed, migrants in an irregular situation are often found among home-based workers (data pointing to this are presented below).

2.1.2. DATA USED BY THIS REPORT: BROAD STROKES AND SNAPSHOTS

Because of the abovementioned limitations, it is not possible to give a complete and seamless global picture of international migrants among care workers in health services, education and household and personal services. Nonetheless, this report attempts to provide broad outlines of the scale and geographical spread of the international migration of care workers; however, the picture is patchy.

The *UN International Migration Report 2015* (UN DESA, 2016a), using national statistics mainly from population censuses, provides the global number (stock) and geographic concentrations of international migrants, who may or may not have moved for employment reasons, who may or may not be economically active in the destination country, and who may or may not be care workers in their country of residence. Published UN data do not state how many of them were care workers or were trained to be care workers in their places of origin; nor do these data differentiate categories of migrants, for example, between “permanent” migrants, “temporary” migrants and refugees and asylum seekers, which are broad types commonly established by national immigration rules. As discussed in subsection 2.2 and section 4 below, these categories imply different rights to residency and to employment, and affect migrant workers’ employment outcomes and working conditions.

The *ILO Global Estimates of Migrant Workers* provides global data on migrant workers, defined as those who are employed or seeking employment among the working-age population in the country of residence (ILO, 2015a). To estimate the population of migrant workers, the ILO used the UN Department of Economic and Social Affairs (UN DESA) migration stock data, so there is a link between the ILO and UN data.⁶ However, this link is not seamless. The ILO estimates are not supposed to cover persons who did not migrate for work reasons, asylum seekers and refugees, and short-term and seasonal migrant workers. However, the UN definition of international migrant does not make these distinctions, and the UN DESA stock data of international migrants, being dependent on national data, may be assumed to have included these specific categories of migrants. The proportions of these categories of migrants cannot be determined.

With regard to data on migrant care workers, global and cross-country data are quite scarce. The UN DESA, together with the OECD, produced an analysis of the international migration of skilled persons, operationally defined as those who have completed tertiary education. The data cover only OECD countries and are not specific to care professions. But they claim that the migration of health professionals follows the trend of skilled migration (UN DESA and OECD, 2013).

⁶ For a more detailed explanation of the estimation methodology used by the ILO to produce the global estimates of migrant workers, see Part II of ILO, 2015a.

Only the OECD has monitored trends in the migration of health workers, providing data through the *International Migration Outlook* reports of 2007 to 2016. There is no other source that provides comparable cross-country data on health workers covering other countries or regions. However, the OECD report is limited in that it focuses only on health professionals, nurses and doctors, except for a brief analysis of older person care workers in 2015.

The ILO, using its estimates of migrant workers based on UN stock data of international migrants and ILO data on labour force participation and employment rates, has produced global and regional estimates of international migrants among domestic workers, i.e. workers who work for and in private households, who make up one broad category of care workers under the definition of care work in this report. The ILO estimates refer to 2013.⁷

Data on migrant teachers are patchy, available only from various country and regional reports that refer to different time periods. To the extent made possible by available recent studies, this report tries to present data on the different regions.

2.2. GENERAL TRENDS IN INTERNATIONAL MIGRATION

2.2.1. OVERVIEW OF INTERNATIONAL MIGRATION⁸

Rates of international migration have increased rapidly in the world. Between 1990 and 2015, the number of international migrants worldwide rose by over 91 million, or by 60 per cent. Much of this growth occurred between 2000 and 2010, when some 4.9 million migrants were added annually, compared to an average of 2.0 million from 1990 to 2000 and 4.4 million from 2010 to 2015. Worldwide, international migrants account for a relatively small share of the total population, about 3.3 per cent of the world population in 2015, compared to 2.9 per cent in 1990. Geographically however, international migrants are concentrated in developed regions, where they accounted for 11.2 per cent of the total population in 2015 compared to only 1.7 per cent in the developing regions.⁹

The increase in the number of international migrants in developed regions resulted from the increase in the number of migrants from countries of both the South and the North (figure 2.1). By contrast, in the developing countries, the growth of the migrant population resulted mainly from an increase in the number of migrants from the South. Between 1990 and 2015, Asia, Europe and North America recorded the largest gains in the number of international migrants (figure 2.2).¹⁰ The United States has consistently hosted the largest number of international migrants (figure 2.3).

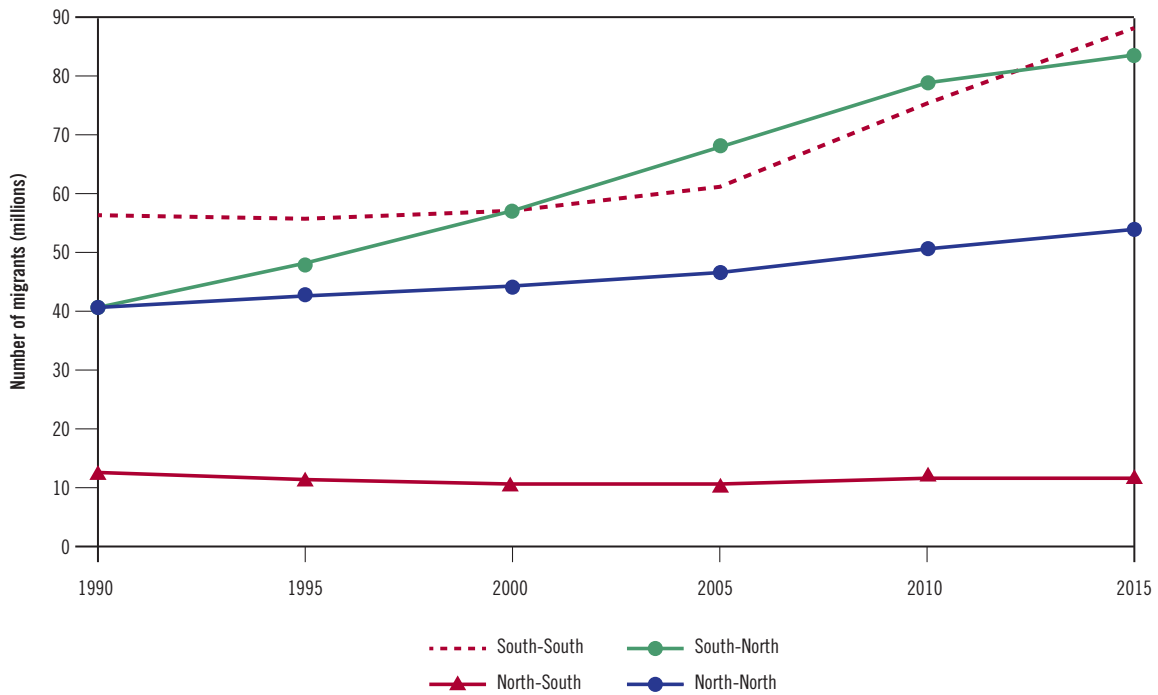
⁷ For more detailed information on the estimation methodology, see ILO, 2015a.

⁸ The principal source for subsection 2.2.1 is UN DESA, 2016a, pp. 1–9.

⁹ According to UN DESA, “developed regions”, referred to also as the “global North” or the “North”, are comprised of all countries or areas of Europe and Northern America, plus Australia, New Zealand and Japan. The term “developed countries” refers to countries in the developed regions. The “developing regions”, or the “global South”, are comprised of all countries or areas of Africa, Asia (excluding Japan) and Latin America and the Caribbean, as well as Melanesia, Micronesia and Polynesia. The term “developing countries” is used to designate countries in the developing regions. The terms “developed” and “developing” describe the clear distinction between rich and poor countries or regions that existed as recently as 1960, but which has since disappeared as many countries of the South have undergone rapid development (UN DESA, 2016a, p. vii).

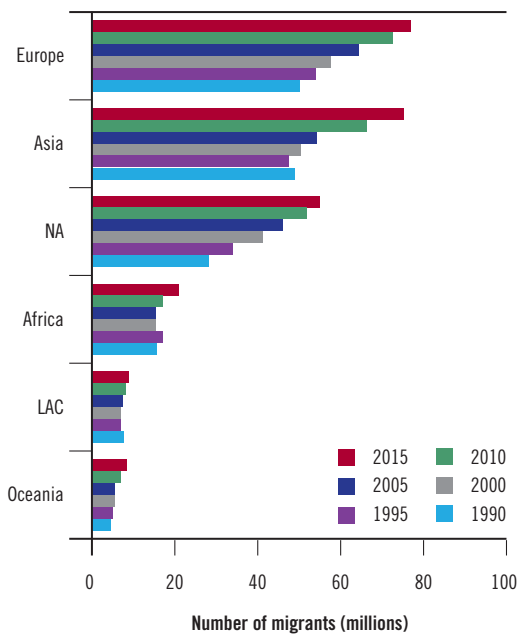
¹⁰ In 2015, nearly two-thirds of all international migrants lived in Europe (76 million) and Asia (75 million). Northern America hosted the third largest number (54 million), followed by Africa (21 million), Latin America and the Caribbean (9 million) and Oceania (8 million) (UN DESA, 2016a).

Figure 2.1. General direction of international migratory flows, 1990–2015



Source: UN DESA, 2016a, p. 2, figure 1.1.

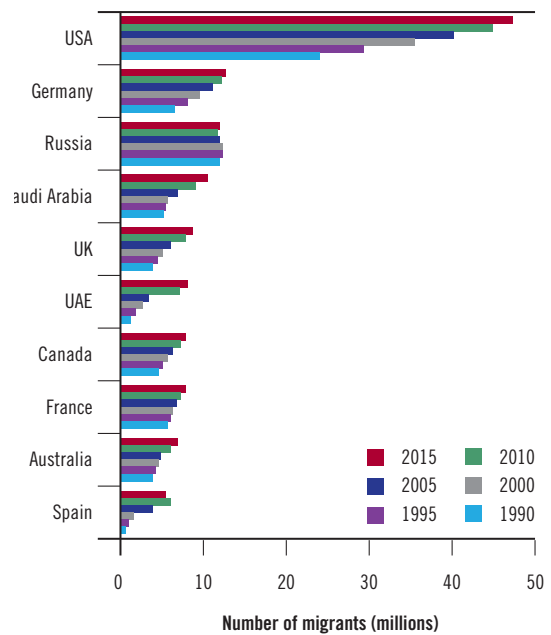
Figure 2.2. Number of international migrants by major regional destination, 1990–2015 (millions)



Note: LAC refers to Latin America and the Caribbean, while NA refers to Northern America.

Source: UN DESA, 2016a, p. 3, figure 1.2.

Figure 2.3. Top ten countries hosting international migrant workers, 1990–2015 (millions)

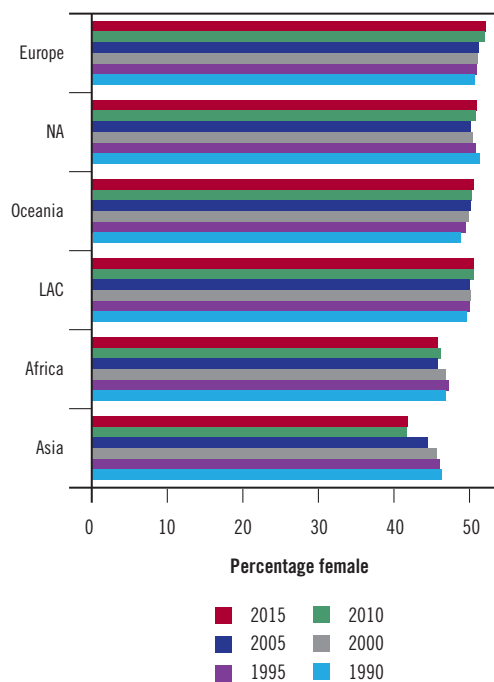


Note: Russia refers to the Russian Federation, UEA refers to United Arab Emirates, UK refers to the United Kingdom of Britain and Northern Ireland and USA refers to the United States of America.

Source: UN DESA, 2016a, p. 5, figure 1.5.

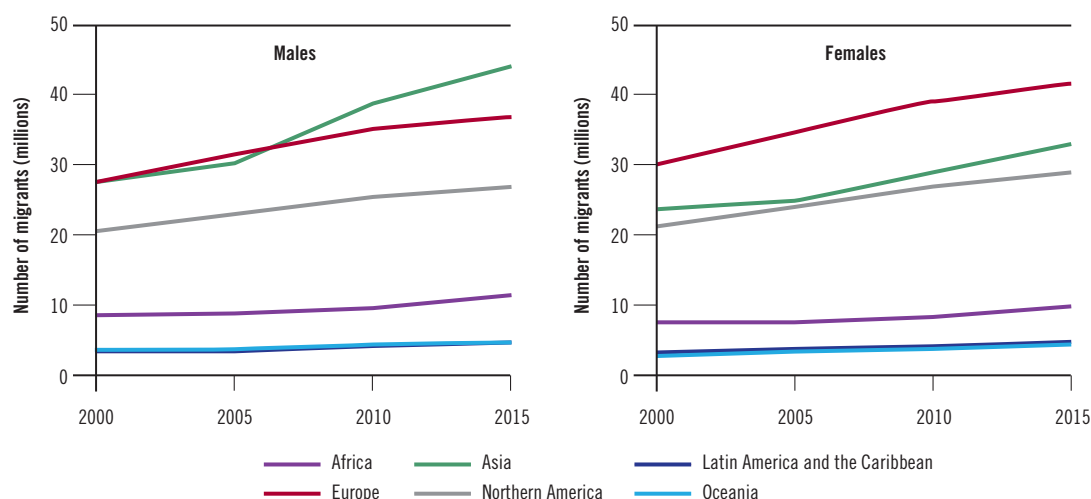
Globally, in 2015, women comprised 48.2 per cent of all international migrants. There are important regional differences, however (figure 2.4). In Europe and Northern America, female migrants outnumber male migrants (52.4 per cent and 51.2 per cent, respectively). This disparity has been traced to female migrants who had arrived decades earlier in areas with long histories of migration, combined with the fact that women tend to have longer life expectancies than men. By contrast, male migrants significantly outnumber female migrants in Asia (58 per cent) and Africa (53.9 per cent), where migration is typically of shorter duration than in Europe and North America.¹¹ Notably, between 2005 and 2015, the share of male migrants increased steeply in Asia (figure 2.5). This increase is attributed to the strong demand for migrant workers in the oil-producing Arab countries and the conflict in the Syrian Arab Republic that has pushed a large number of refugees (the majority of whom are men) to live in neighbouring countries.

Figure 2.4. Percentage of women among international migrant workers by major area of destination, 1990–2015



Note: LAC refers to Latin America and the Caribbean, while NA refers to Northern America.
Source: UN DESA, 2016a, p. 8, figure 1.7.

Figure 2.5. Number of male and female international migrants by region, 1990–2015 (millions)



Source: UN DESA, 2016b, p.11, figure 5.

¹¹ The proportion of female migrants in high-income non-OECD countries fell from 45 to 40 per cent, while the share of female migrants in high-income OECD countries increased slightly between 2000 and 2015 (from 51 to 52 per cent). While the average share of women migrants in OECD countries gradually declined to 47 per cent in 2014, a few countries continued to have high flows of women, and therefore a higher share of women than men – the United States, Ireland, Australia, Canada, France and Israel, partly explained by the large share of family unification migration (OECD, 2015).

The median age of international migrants worldwide was 39 years in 2015, a slight increase from 38 years in 2000. Those living in Africa were the youngest (median age of 29 years), followed by Asia (35 years) and Latin America and the Caribbean (36 years). In contrast, migrants were older in Europe, Northern America and Oceania, where the median age was 43, 42 and 44 years, respectively. The migrant stock in Asia, Latin America and the Caribbean and Oceania has become younger.

2.2.2. INTERNATIONAL MIGRANT WORKERS: GLOBAL OVERVIEW¹²

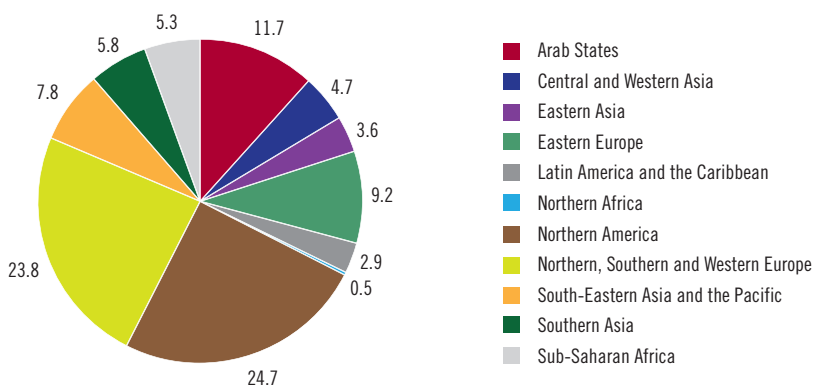
Of the estimated 232 million international migrants in 2013, 207 million (89.2 per cent) were of working age (15 years old and over). Of this working-age migrant population, 150 million were working or economically active – in percentage terms, 64.6 per cent of international migrants and 72.5 per cent of the migrant population aged 15 years and over.

International migrants tend to have a higher labour force participation rate than non-migrants (72.7 per cent as opposed to 63.9 per cent), thus migrants make up 4.4 per cent of all workers but 3.9 per cent of the total population. Men outnumber women among migrant workers (55.7 per cent against 44.3 per cent of migrant workers), and this is due to two factors: fewer women than men among migrants (48.1 per cent); and a lower labour market participation rate among women migrants.

The greatest proportion of migrant workers is employed in services (63.4 per cent) and domestic work (7.7 per cent). The rest are employed in agriculture (11.1 per cent) and industry (17.8 per cent (ILO, 2015a, p. 9). The particular migration trends of domestic workers are discussed in further detail in subsection 2.5 below.

Nearly half of all migrant workers are in Northern America (24.7 per cent) and Northern, Southern and Western Europe (23.8 per cent), and more than one-tenth are in the Arab States (figure 2.6). Similar to the overall international migration trend (refer to subsection 2.2.1), migrant workers are highly concentrated in high-income countries (figure 2.7). Unlike Northern America and Northern, Southern and Western Europe, whose shares of female migrant workers outweigh that of male migrant workers, the Arab States and Central and Western Asia present a contrasting picture, which is consistent with the pattern mentioned in subsection 2.2.1 (figure 2.8).

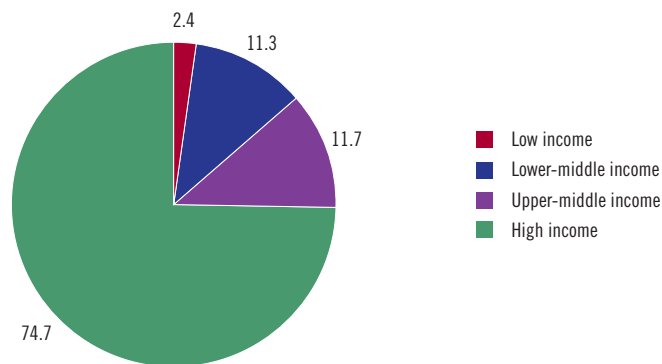
Figure 2.6. Distribution of migrant workers by subregion, 2013 (%)



Source: ILO, 2015a, p. 17, figure 2.17.

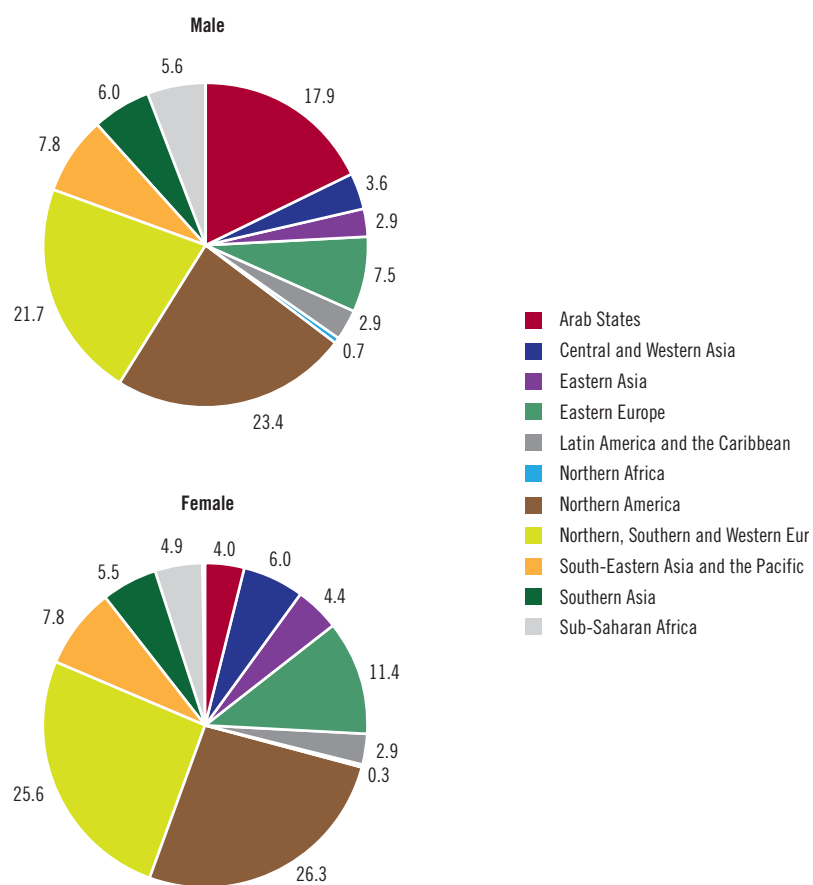
¹² Sourced solely from ILO, 2015a.

Figure 2.7. Distribution of migrant workers by income level of countries (%)



Source: ILO, 2015a, p. 10, figure 2.7.

Figure 2.8. Distribution of migrant workers by sex and subregion, 2013 (%)



Source: ILO, 2015a, p. 17, figure 2.18.

2.2.3. PERMANENT AND TEMPORARY LABOUR MIGRATION: OECD CASE

The stocks of international migrants and of international migrant workers presented above (subsections 2.2.1 and 2.2.2) consist of different types of migrants. First, depending on the type of migration channels used to enter the country of destination, a migrant may have full, limited or no rights to reside and/or work in that country. Differences in migrant status and rights are relevant for this report because they affect the employment situation of migrant care workers or migrant workers who end up employed in the care economy (“would-be” care workers) in countries of destination. As will be discussed in section 4, migrant care workers have entered their host countries through various admission channels; and some entered, stayed and/or worked without the proper legal permission to do so. Second, not all migrant workers (employed or looking for work in the country of destination) migrated or were admitted for employment-related reasons.

Countries basically have two admission systems for foreign nationals: permanent migration and temporary migration (box 2.1). National laws set a demarcation line between these two systems but that line may become blurred with changes in immigration rules and the introduction of new types of entry visas (Batalova, 2006).¹³

Box 2.1. Definition of permanent and temporary migration

There is no internationally established definition of these two types of migration. However, the OECD provides definitions that underlie its harmonized (standardized) cross-country statistics for comparability across its member countries.

Permanent migration is defined as the regulated movement of foreigners considered to be settling for the long term in the country from the perspective of the receiving country, although in practice this may not turn out to be so due to changes in intentions, etc.¹⁴ Permanent or permanent-type migrants include persons who have been granted the right of permanent residence upon entry (i.e. are on the track that normally leads to permanent residence), persons admitted with a permit of limited duration that is more or less indefinitely renewable plus persons entering with the right of free movement (such as EU citizens within the European Union). Generally, the OECD has identified six categories of permanent migration: work-related, accompanying family of workers, family reunification and family formation, humanitarian and accompanying family, persons moving under a free-movement regime and others (including ancestry-based, retirees, persons of independent means, etc.).

In contrast, temporary migration refers to the entry of temporary visitors for both tourist and business reasons, and persons who enter the country on a permit that is not renewable or is renewable only on a limited basis, as well as persons under a free-movement regime who enter for reasons similar to those of persons with a limited renewal permit.¹⁵ Temporary migrants include tourists, business visitors, seasonal workers, international students, exchange academics and researchers, trainees, service providers and other types of temporary workers.

Source: Fron et al., 2008.

¹³ For example, in the United States, although the law attempts to keep the temporary and permanent visa systems separate, in practice an expanding number of visas act as “transmission belts”, allowing people who are initially temporary visitors to become permanent residents (Batalova, 2006).

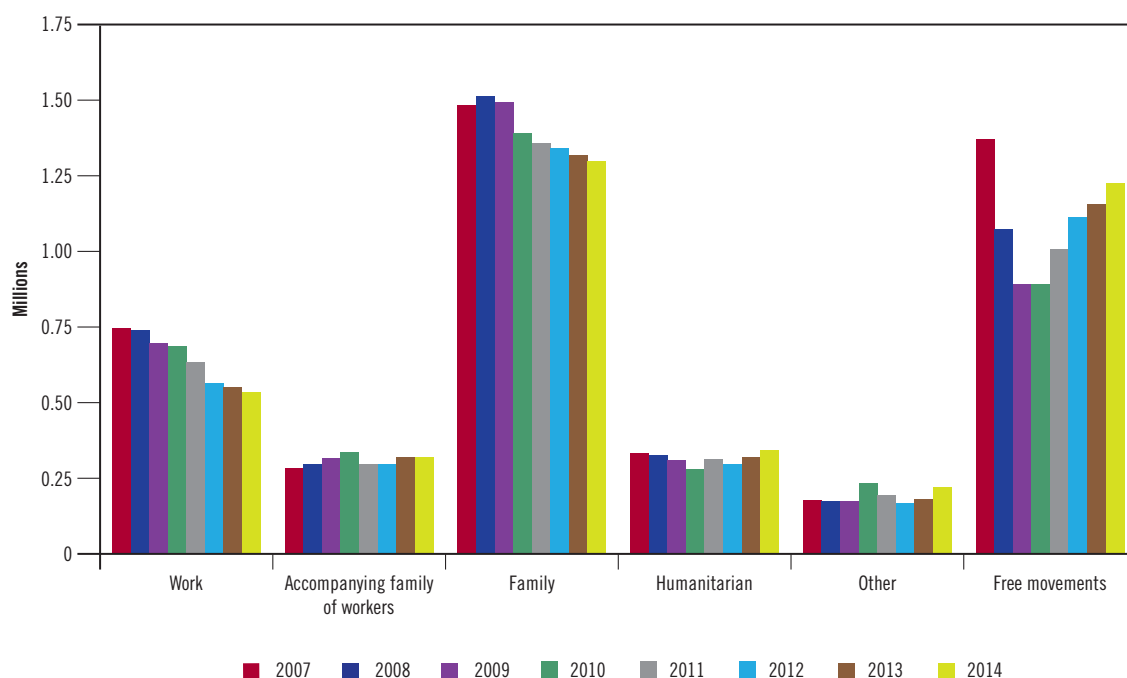
¹⁴ Fron et al., 2008 provide further discussion on the nuances of the concept of permanent migration and why it is not the same as the UN concept of “long-term” migration.

¹⁵ The right of free movement exists within the European Union as well as in South America in the context of the Southern Common Market (MERCOSUR) trade agreement. One of the four freedoms enjoyed by EU citizens is the free movement of workers, which includes the right of movement and residence for workers, the right of entry and residence for family members, and the right to work in another Member State and be treated on an equal footing with nationals of that Member State. Restrictions apply in some countries for citizens of new Member States (European Parliament, 2017).

The OECD’s International Migration Outlook reports provide cross-country data that are disaggregated by type of migration. While only offering a partial picture, the OECD patterns are important because OECD countries are a principal destination of migrants (OECD, 2015, 2016a). The OECD statistics, however, do not include “unauthorized migration”, i.e., a migrant who at entry or any subsequent stage of migration did not have legal permission to stay or work in the receiving country. After having declined from 4.7 million in 2009 to 4 million in 2010–12, the number of permanent migrants has gradually increased. In 2014, the number of permanent immigrants was estimated to stand at 4.3 million; in 2015, at 4.8 million. Family reunification and free movement have accounted for the bulk of permanent migration flows to OECD countries: 33 per cent and 32 per cent respectively in 2014 (figure 2.9). The trend in recent years has seen the number of persons admitted for family reunification and for work reasons slightly decline, while the numbers of those admitted for humanitarian reasons and those with right of free movement have slowly increased (figure 2.10).¹⁶

Permanent migrants admitted for work-related reasons (referred to as permanent labour migrants) comprised only an average of 14 per cent across OECD countries in 2014. Behind this average, there are some stark differences between countries. Two-thirds of OECD countries saw an increase in the number of permanent labour migrants between 2013 and 2014, notably France (up by 25 per cent) and Canada (up by 20 per cent). In contrast, Italy and Spain saw very sharp drops (by 33 per cent and 20 per cent, respectively) while the United States and the United Kingdom registered some considerable decreases (down by 6 per cent).

Figure 2.9. Permanent migration flows to OECD countries by category of entry, 2007–14 (in millions)



Source: OECD, 2016a, p. 19, figure 1.2.

¹⁶ Although comprising just 9 per cent in 2014, the numbers of new asylum seekers rose by 6 per cent between 2012 and 2013 and by 13 per cent in 2013–14. The top five destination countries of asylum seekers are Germany, the United States, Turkey, Sweden and Italy; France comes sixth (OECD, 2016a).

Figure 2.10. Percentage change in categories of permanent migration, 2012–13 and 2013–14

Source: OECD, 2016a, p. 19, figure 1.2.

Temporary migration to OECD countries for work-related reasons (temporary labour migration) consists of seasonal workers,¹⁷ intra-company transferees, postings of workers in the EU, paid trainees, working holiday-makers,¹⁸ au pairs and other workers admitted under temporary migration schemes (OECD, 2013, pp. 26–27; OECD, 2015, pp. 21–26; OECD, 2016a, pp. 22–28). Temporary labour migration concerns workers of all skill levels. Intra-company transferees and posted workers in the EU are “employees or self-employed workers who cross borders [from their origin country to the host country] to supply services for a set length of time to private individuals, firms, or governments” (OECD, 2015, p. 23).¹⁹ In the EU, under the Directive 96/71/EC concerning the posting of workers,

¹⁷ Seasonal labour migration is often linked to agricultural activities but can also cover non-farm activities with seasonal peaks, especially those linked to hospitality (e.g. hotels, catering, retail and tourist-related services).

¹⁸ The chief purpose of working holidays is to foster cultural exchange and international understanding between young people through temporary employment in a foreign country. In 2013, Australia, the United States, Canada and New Zealand were the destinations of choice for 93 per cent of the 485,000 foreigners who migrated as working holiday-makers. In 2013, 110,000 foreign paid trainees were admitted into OECD countries as part of a trend that has been stable since 2009. The highest figures are recorded in Japan and the Republic of Korea. However, the total figure is underestimated, as a number of countries do not distinguish between paid trainees and students (OECD, 2015, p. 26).

¹⁹ According to the OECD (2015, p. 23): “Unlike classic labour migrants, when they are employed, they are recruited by a company located in their origin country and not in the country where they provide their services. When self-employed, their company is generally not located in the country where services are provided. Employers and employees are generally affiliated to the social security system where the company is located. ... Although service providers’ jobs are often temporary, intra-company transfers may be long-term postings to manage operations or take up administrative duties in the subsidiary of an international company. In such cases, the transferee usually becomes an employee of the subsidiary in the host country. So, although the company back in the country of origin is not, strictly speaking, supplying a service, work and residence permit systems do not always distinguish between posted employees and transferees. Both are granted the same kind of permit”.

companies are allowed to post workers to other countries for a maximum of two years.²⁰ Most intra-EU postings of workers in 2014 occurred in the services sector (33 per cent), which includes care services and construction (44 per cent).²¹

Several OECD countries admit temporary foreign workers to help fill gaps in their labour markets. The ratio of temporary foreign workers to permanent immigrants admitted in 2010 was very high in Japan, New Zealand and Germany (between 1.6 and 1.8) (Wilson, 2013). Australia also admitted more temporary workers than permanent migrants, at a ratio of roughly 1.3. By contrast, the United States, a prime migration destination, issues significantly fewer temporary worker visas than permanent immigrant visas (612,000 compared to 1 million in 2012).

Labour migration to the OECD countries has generally followed changes in economic activity and conditions (such as seasonal peaks, the 2007/08 economic crisis and post-crisis upturn). It decreased strongly in response to the economic crisis and for the whole group of OECD countries currently remains significantly below the 2.5 million level it had reached in 2007 and 2008. Migration due to “free circulation” rights has also led to an apparent decline in temporary labour migration. For example, in 2011, the decrease in the number of temporary labour migrants was principally attributable to large numbers of seasonal migrants in Germany who were no longer being captured in the statistics, because the workers so engaged tended to fall under the EU free-circulation regime. Most EU Member States saw a decrease in the number of permits issued to seasonal workers between 2013 and 2014, mainly due to the fact that Bulgarian and Romanian nationals no longer needed work permits as of 1 January 2014 (OECD, 2016a, p. 23). The mobility of workers between EU countries has continued to rise and concerns various types of movement: postings, cross-border work, temporary work, etc. In the case of temporary labour migration to *non-European* OECD countries, this has returned to its pre-2007/08 economic crisis level, and in some cases has exceeded it (OECD, 2016a, p. 22).

2.2.4. TEMPORARY LABOUR MIGRATION: OTHER REGIONS

The Middle East presents another snapshot of labour migration. The six Gulf Cooperation Council (GCC) countries²² are home to the world’s largest population of temporary labour migrants – mostly employed in construction and domestic work – principally due to the booming oil economy. Between 1990 and 2015, the number of international migrants hosted by the Arab States increased threefold, from 9.8 million to 35 million (ILO ROAS, 2017a). The GCC countries have hosted by far the largest migrant population in the Arab region, and one of the largest worldwide. Their total migrant stock stands at 25.4 million, with the Kingdom of Saudi Arabia (KSA) hosting the largest number of migrants in the region as well as being the fourth largest destination country worldwide, followed by the United Arab Emirates (UAE), which is the world’s sixth largest destination country. With the exception of Oman and KSA, migrants make up the majority of the total population in GCC countries (88 per cent in the UAE, 75 per cent in Qatar, 73 per cent in Kuwait and 51 per cent in Bahrain);

²⁰ This Directive of the European Parliament and of the Council applies to “undertakings established in a Member State, which in the framework of the transnational provision of services, post workers”, and defines “posted worker” as “a worker who, for a limited period, carries out his work in the territory of a Member State other than the State where he normally works” (EUR-LEX, 1997). The worker is subject to the labour law of the country of posting but social security contributions are paid to their resident country of origin (OECD, 2016a, pp. 24-26). In March 2016, the European Commission proposed a revision of the rules on posting, including applying to posted workers the same rules on remuneration that are applied generally to local workers, and not just the payment of the minimum wage (European Commission 2016a). The posting shall not exceed two years and temporary work agencies shall be obliged to provide equal treatment for all workers established in the same country (OECD, 2016a, p. 26). These measures are in response to the growing number of critiques/complaints about the use of posted workers to take advantage of the lower labour cost of workers from other countries.

²¹ Between 2010 and 2014, the number of posted workers increased by 38 per cent (OECD, 2015, p. 2).

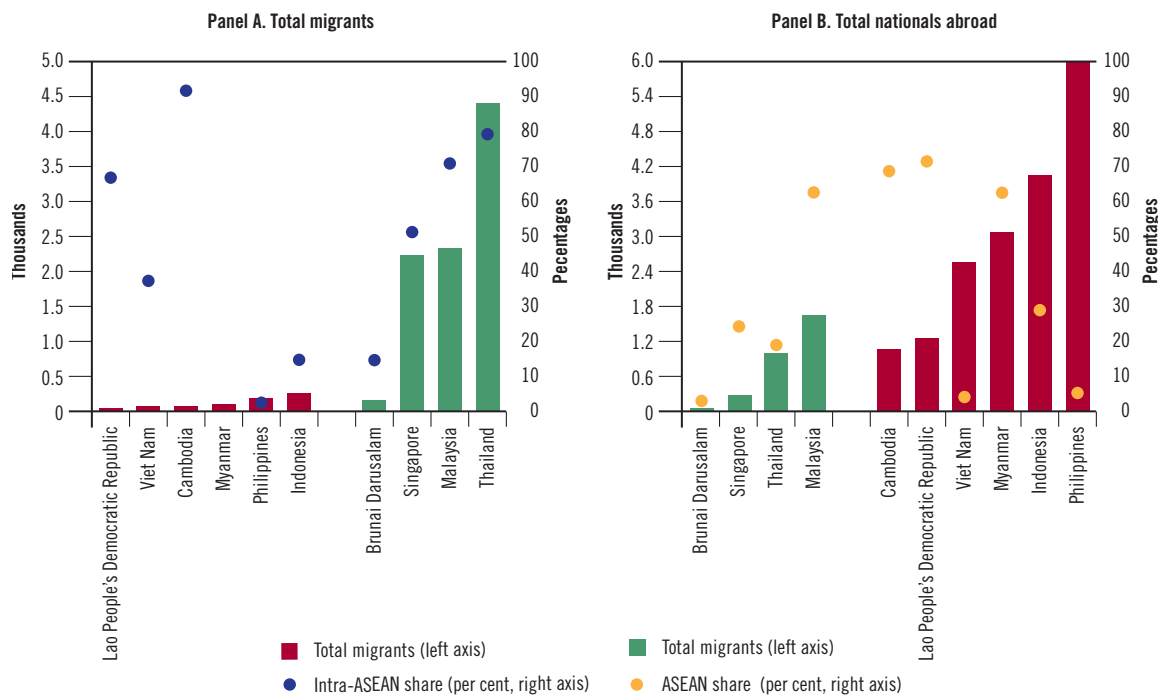
²² The Kingdom of Bahrain, the State of Kuwait, the Sultanate of Oman, the State of Qatar, the Kingdom of Saudi Arabia (KSA) and the State of the United Arab Emirates (UAE).

and the overwhelming majority are in the labour market (with an average labour force participation rate of 89 per cent). Migrant workers predominately come from Asia, particularly South Asia, but increasingly from Africa.

The Arab region stands out among destination countries as having one of the lowest proportions of women among international migrants. The proportion of migrant women varies from country to country but, on average, the share of women among the total stock of migrants and refugees had increased from 10 per cent in the late 1970s-early 1980s to 39 per cent in 1990 (UN DESA, 2006; ILO ROAS, 2017a). As of 2015, the average share of migrant women stands at 33 per cent (ILO ROAS, 2017a).

There are also substantial temporary labour migration flows, especially for domestic work, between countries within Asia. The ASEAN subregion²³ is an important origin as well as destination of international migrant workers, many of them domestic workers, including caregivers. According to the ILO International Labour Migration Statistics (ILMS) database²⁴ that covers the ASEAN subregion, of the 10.2 million international migrants living in ASEAN countries in 2013, about two-thirds are from within the region itself (figure 2.11) (ILO ROAP, 2015). During the 1960s and 1970s,

Figure 2.11. Estimated stocks of migrants in ASEAN countries, ASEAN nationals in other countries and shares of intraregional migrants, 2013



Notes: (a) In panel A, the bars represent migrants (thousands) in each ASEAN country and the blue points are percentage shares of intraregional (ASEAN) migrants. (b) In panel B, the bars represent nationals overseas (thousands) and the yellow points are the shares of ASEAN nationals in the country. (c) PDR – People's Democratic Republic.

Source: ILO ROAP, 2015, p. 16, figure 2.9.

²³ The ten ASEAN member countries referred to here are: Brunei Darussalam, Cambodia, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Viet Nam.

²⁴ The ILMS Database gathers together a range of statistical sources relating to international migrants and international migrant workers in the ten ASEAN member States. For harmonized global estimates of stocks of international migrants, it draws on three global sources: the World Bank's Global Bilateral Migration Database; the UN DESA's International Migrant Stock; and the World Bank's *Bilateral Migration Matrix 2010* and *Bilateral Migration Matrix 2013*. For more information, see ILO ROAP, 2015.

there were only about 700,000 intraregional migrants in ASEAN countries, alongside many more from other parts of the world. During the 1980s, the number of intraregional migrants in ASEAN countries multiplied rapidly, and subsequently outnumbered those from the rest of the world. At the same time, millions have migrated out of the subregion, in increasing numbers since the 1970s. Some 14.5 million ASEAN nationals were estimated to be living outside the subregion in 2013 (figure 2.11). ASEAN women nationals have generally been slightly fewer than men nationals among both intra-ASEAN migrants (in 2013, 93 women to 100 men) and ASEAN nationals living in non-ASEAN countries (97 women to 100 men). The origin and destination of migratory flows of ASEAN nationals within and outside the subregion have undergone changes over the past decades. Currently, the countries which host the largest number of ASEAN migrants are Thailand, Malaysia and Singapore. The countries that have the largest number of nationals overseas are the Philippines, Indonesia, Myanmar and Viet Nam; but, unlike other ASEAN countries, the overwhelming majority of migrants from the Philippines and Viet Nam have left the subregion.

With regard to Latin America and the Caribbean, country data collected under the Continuous Reporting System on International Migration in the Americas (SICREMI – its acronym in Spanish), show that intraregional migration is much more closely related to work than to family reunification, humanitarian reasons or the pursuit of education (OAS, 2011, pp. 9–10). Comparable data for 2007–08 and 2008–09 showed that temporary labour immigration exceeded permanent labour immigration in Argentina (by ten to one) and in Ecuador (by a small margin). Most of the temporary labour migration in Argentina consisted of workers from MERCOSUR countries²⁵ searching for work, with employer-driven migration less likely.²⁶

2.3. MIGRATION OF HIGH-SKILLED/LESS-SKILLED WORKERS: IMPLICATIONS FOR WOMEN AND CARE WORKERS

Skill level may be based on the skill requirements of a job or on the educational level of the migrant worker. Available cross-country data (OECD statistics) use educational attainment to indicate the skill level of migrants (OECD, 2008b; UN DESA and OECD, 2013; Arslan et al., 2016). National concerns of OECD countries about less-skilled migration are focused on the skill level of migrants, which is regarded as one determining element in their integration and the support that migration can offer to economic growth (OECD, 2008b).²⁷ Less-skilled migrants are regarded as those whose educational level is less than upper secondary; high-skilled are those with tertiary education.²⁸ Of course, the situation exists where workers with high levels of education and specialized skills occupy less-skilled jobs.

²⁵ A multilateral accord facilitates movement within the MERCOSUR zone.

²⁶ “Unauthorized migration” is the term used by SICREMI to refer to immigration that takes place contrary to the laws and regulations of the destination country, whether at entry or following entry. Some immigrants actually enter legally, with a tourist or visitor visa or under visa-free provisions, but then overstay the conditions of the visa or entry. Others may enter with false documents or surreptitiously cross land or water borders. Not all are “undocumented”, since many will possess passports, identity cards or visas and even undergo inspection at border control points (OAS, 2011, p. 12).

²⁷ Relative to lower-educated migrants, higher-educated migrants are likely to have better outcomes in the host country, both in terms of employment and in terms of the performance of their children (OECD, 2008b).

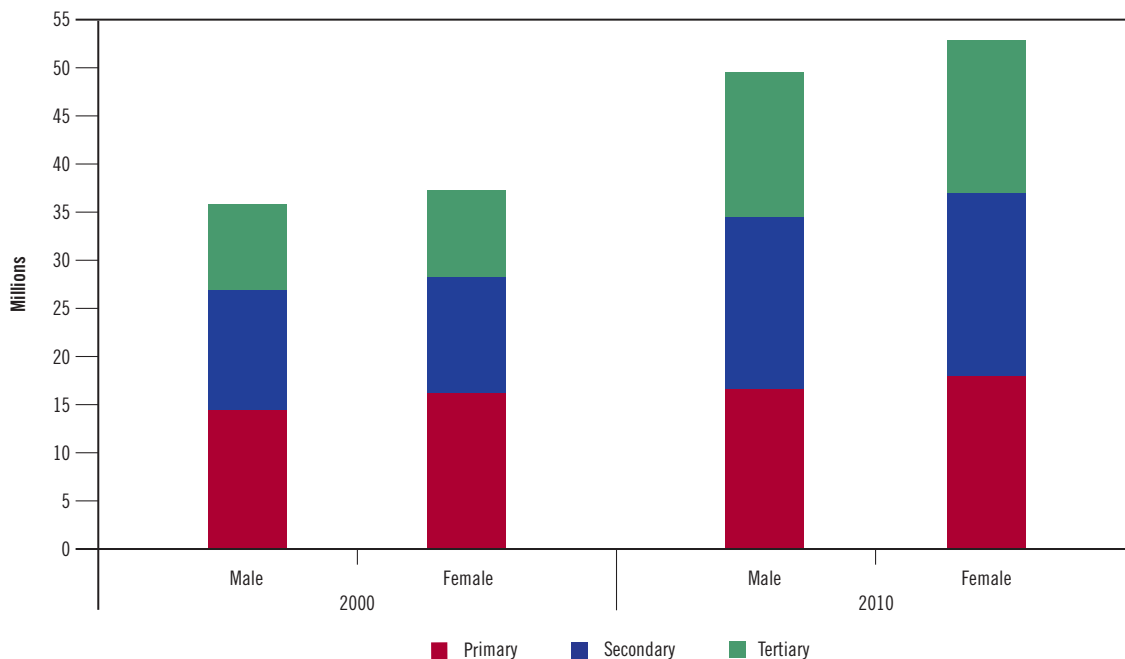
²⁸ By definition, trades people and artisans with upper secondary education or with higher vocational training are excluded from the low-educated group (OECD, 2008b). It is recognized that skill–job mismatch occurs. Some lower-skilled jobs are occupied by more highly educated migrants, at least initially. Although over-qualification of migrants remains a common phenomenon in many OECD countries, many higher-skilled migrants gradually progress out of low-skilled jobs over time and experience some degree of wage convergence with natives (OECD, 2007a).

2.3.1. MIGRATION OF HIGHLY EDUCATED PERSONS

The migration flows of teaching and health-care professionals are mirrored in the general migration trends of highly educated persons to OECD countries (Aluttis et al., 2014; OECD, 2015). It is therefore relevant to look at the migration trends of highly educated migrants. In 2010/11, about 6 per cent of doctors and nurses in the world had emigrated to an OECD country.

The joint work of the OECD, the University of Oxford's Centre on Migration, Policy and Society (COMPAS) and the Development Research Group of the World Bank, carried out within the framework of the Global Knowledge Partnership on Migration and Development's (KNOMAD) Thematic Working Group on Labor Migration, provides a cross-country data set on educational levels of international migrants, but covers only the OECD countries (Arslan et al., 2016).²⁹ The period 2000–10 saw an increase in human capital levels of the migrant populations in OECD countries. Although the proportions of both natives and foreign-born with tertiary education increased noticeably, the improvement was much larger for migrants – from 23.6 per cent to 29.7 per cent among migrants, 19.1 per cent to 23.4 per cent among natives (Arslan et al., 2016, p. 6). As a result, foreign-born workers with tertiary education increased their share of total population (foreign-born and natives) from 11 per cent to 14 per cent. As may be expected, there are significant variations between OECD countries. In some, the proportion of highly educated migrants in the country's migrant population is high (e.g. 52 per cent in Canada, 47 per cent in the United Kingdom); in others, relatively low (e.g. 17 per cent in Germany and 13 per cent in Italy).

Figure 2.12. OECD countries – migrant men and migrant women by educational level, 2000 and 2010



Source: Arslan et al., 2016, p. 8, figure 1.

²⁹ The data were drawn from the OECD Database on Immigrants in OECD and non-OECD Countries (DIOC). The KNOMAD Thematic Working Group on Labor Migration is chaired by COMPAS, ILO and the World Bank.

The greater proportion of high-skilled migrants to OECD countries originated from Asia. Together, India, China and the Philippines accounted for one-fifth of all tertiary educated immigrants in OECD countries in 2010/11 (UN DESA and OECD, 2013). If one were to look for indications of a “brain drain” to the OECD, in 2010/11 one in every nine persons born in Africa with a tertiary diploma was living in the OECD; one in 13 of those born in Latin America and the Caribbean; and one in 30 of those born in Asia (UN DESA and OECD, 2013). For virtually all countries of origin, the emigration rate of the tertiary educated exceeded the total emigration rate, reflecting the selectivity of migration by educational attainment (UN DESA and OECD, 2013).³⁰

2.3.2. HIGHLY EDUCATED MIGRANT WOMEN: UNEQUAL RECOGNITION AND ACCESS

Migrant women tend to be better educated than migrant men (figure 2.12). Between 2000 and 2010, the number of tertiary educated female migrants in OECD countries increased by 7.6 million (88 per cent) while the parallel increase among male migrants was 5.9 million (64 per cent). Similarly, the shares of primary educated migrants fell for both genders between 2000 and 2010, but the share for women fell more sharply than that for men.

According to the International Organization for Migration (IOM) and OECD Development Centre (2014), between 2000 and 2011, emigration rates of women with tertiary education were higher than those of men (13.9 per cent and 9.7 per cent, respectively). At the regional level, emigration rates were higher among women in Africa (27.7 per cent versus 17.1 per cent among men) and Latin America (21.1 per cent versus 17.9 per cent among men).³¹

However, despite their high educational attainment levels, women remain, on average, underrepresented among migrants admitted for work reasons (IOM and OECD Development Centre, 2014). The reason for this was determined by the IOM and OECD Expert Group Meeting on the Migration of Highly Skilled Women to be partly attributable to biases within the admission schemes designed to attract or regulate skilled and highly skilled migrants.³² They observed that admission systems tend to prioritize professions linked to production sectors (information technology (IT), engineering, finance, business management) which tend to hire men, rather than “welfare-related” professions, such as health, education and public services which hire more women. These biases have consequences for the migrant status of women, their access to work permits and recognition of their degrees or professional experience (IOM and OECD Development Centre, 2014).

It should be noted that, although there are men in care occupations, women dominate in teaching, health and domestic work jobs. Female migrants tend to be over-represented in these occupations as well (Fleury, 2016, p. 11; ILO, 2013, ILO, 2015a).³³ The demand for workers in older person care, childcare and family and household care jobs, both in institutions and in private homes, has grown considerably, and this demand has been met largely by women. Most of these jobs (e.g. nursing care assistants, nursing aides, home care aides, household and personal services workers, nannies and domestic workers more broadly) are considered low skilled (OECD, 2008b). Various migration barriers have channelled immigrants (whether admitted for work reasons or not, to take up permanent residence or for a temporary stay, whether entering through regular or irregular channels) into care

³⁰ This was the case for 137 of 145 countries of origin with available data. In 2010/11, Burundi, Lesotho, Malawi, Maldives, Mozambique, Namibia, Niger, Papua New Guinea, the United Republic of Tanzania and Zambia experienced emigration rates of the highly skilled which were more than 20 times the total emigration rates.

³¹ Results derived from analysis of data from the Database on Immigrants in OECD and non-OECD Countries (DIOC).

³² Expert Group Meeting held in Geneva, 3–4 April 2014 (IOM and OECD Development Centre, 2014).

³³ This is the global situation; there are, naturally, differences at the country level.

jobs that are in high demand, largely labour-intensive but low-paid and often precarious (see the discussion in section 4).

A report by the OECD (2007a) looked at the issue of over-qualification of immigrants in OECD countries and concluded that, regardless of the definition used and the country in question, immigrants are more likely than native-born workers to hold jobs for which they are over-qualified.³⁴ Over-qualification rates are much higher among foreign-born women in comparison to foreign-born men, native-born women and native-born men, with a few exceptions (OECD, 2007a, p. 139).³⁵ Newly arrived immigrants are more likely than the native-born to accept unskilled jobs, even arduous and low-paying ones (OECD, 2007a, p. 140).

ILO country case studies of Belgium, France, Italy and Spain (Gallotti and Mertens, 2013, p. 11) provide interesting insights into the educational profile of migrant domestic workers, who are regarded by immigration policy, and generally by society, as low-skilled. While there were notable differences in educational attainment among the migrants according to their country of origin (with Asian and Eastern European workers often having higher educational attainment levels), in general, migrants possessed higher levels of education than nationals employed in domestic work. In Italy, for example, around 44 per cent of migrant domestic workers held an upper secondary or university degree; in Spain, more than half of Latin American domestic workers (the largest migrant group in Spain) held a minimum of a secondary degree. In France, 50 per cent of workers providing care-related services (“aide à domicile”) held a professional or secondary school diploma, while the percentage was slightly lower for those providing household services.

2.3.3. DUAL APPROACH: PREFERENTIAL TREATMENT FOR HIGH-SKILLED MIGRANTS

It is important to bear in mind that most developed countries have adopted a dual approach towards high-skilled and less-skilled migrants. Migration policies have concentrated on attracting high-skilled workers, by according them preferential treatment with respect to admission, residence and labour market access. However, labour market shortages are also appearing in many lower skilled jobs, as fewer native-born people are available and/or willing to perform low-wage jobs in many OECD countries. Unlike highly educated migrants, migrants with lower educational attainment (and migrants destined for jobs with lower educational requirements) are subject to more stringent labour market and other types of tests, and more restrictive controls concerning residence and labour market mobility.

For example, the EU Blue Card Directive³⁶ sets entry and residence conditions for “highly qualified” non-EU nationals wishing to work in a highly qualified job in an EU country and for their families (EUR-Lex, 2017; European Commission, 2016a), while different sets of rules and conditions apply to low-skilled migrants, such as the recent Directive on third-country seasonal workers (Council of the European Union, 2014) (box 2.2). In the past decade, as OECD countries vie to attract the most highly educated professionals for their key industries, they have adopted immigration policies and regulatory changes that have moved towards much more selective admission and greater preferential treatment for highly skilled migrants (see box 2.3) (OECD, 2015, p. 11; OECD, 2016a, pp. 41–42).

³⁴ Over-qualification was examined using a normative-type measure based on the correspondence between level of education and requisite qualifications for the job held. It was also analysed from the viewpoint of wages (where the wage distribution by level of education indicates whether a person is over-qualified or not). The results from these two types of measurement led to the same conclusion (OECD, 2007a, pp. 131–159).

³⁵ The difference in over-qualification rates between foreign-born women and foreign-born men is quite small in the cases of Ireland, the Netherlands, Portugal, Sweden, the United Kingdom, and the United States (OECD, 2007a, p. 139).

³⁶ The first Blue Card Directive was issued in 2009. This was revised in 2016.

Box 2.2. EU Blue Card Directive vs EU Seasonal Workers Directive: Some points of comparison

1. The EU Blue Card

1.1. Provisions of the Directive of 2009 concerning entry, residence and employment (EUR-Lex, 2017):

- Successful applicants will be issued with an EU Blue Card valid for a standard period of 1–4 years, depending on the EU country concerned, or for the duration of the work contract, if this is shorter than the standard period of validity, plus three months.
- The application may be made by the individual and/or their employer, depending on the EU country.
- For the first two years, EU Blue Card holders are restricted to highly qualified jobs that meet the criteria for admission. After that they may apply on equal terms with a country's nationals for other highly qualified employment, depending on the EU country concerned.
- EU Blue Card holders and their families can enter, re-enter and stay in the EU country that issues the card and can pass through other EU countries.
- EU Blue Card holders enjoy the same rights as a country's nationals in terms of working conditions, education, recognition of qualifications, aspects of social security and freedom of association. EU countries may restrict some of these rights, particularly those relating to educational grants and loans.
- After 18 months' legal residence, an EU Blue Card holder may be offered assistance to obtain the necessary visa to move to another EU country.

1.2. In 2016, the Blue Card rules were revised to improve the attractiveness of the EU countries to highly qualified non-EU migrants. The changes introduced the following (European Commission, 2016a):

- more flexible admission conditions
 - lower salary threshold
 - lower minimum duration of six months (reduced from 12 months) for the initial contract
 - simpler rules for recent graduates and workers in occupations experiencing shortfalls
 - recognition of the equivalence of professional experience and formal qualifications
- simpler procedures
 - applications may be submitted from outside the EU as well as from within the EU (previously only offered in exceptional circumstances)
 - reduced processing time (from 90 to 60 days maximum)
- broader rights
 - more flexible access to the labour market – easier access to other high-skilled jobs, the right to engage in additional self-employed activity
 - access to EU long-term residence status after three years of continuous residence in the same state (previously five years in the EU)
- easier travel within the EU
 - for short-term business trips across the EU
 - faster procedures and fewer conditions applicable when taking up a new job in another EU country.

2. Provisions of the Seasonal Workers Directive (Council of the European Union, 2014):

- Admission conditions for third-country (non-EU) nationals include, inter alia:
 - a work contract or a binding job offer specifying essentials such as pay and working hours
 - evidence that the worker will stay in accommodation that meets the general health and safety standards of the Member State and that the rent will not be excessive or automatically deducted from the wage.
- Temporary nature of the right to stay:
 - seasonal workers retain their principal place of residence in a third country and stay legally and temporarily in the EU to carry out an activity which is dependent on a given season, typically in agriculture or tourism. States can apply the rules to other sectors, provided that social partners are consulted
 - the maximum period of stay for seasonal workers is between five and nine months in any 12-month period.
- Limited mobility in the labour market:
 - seasonal workers who are already in an EU Member State can extend their work contract or change their employer at least once, under certain conditions
 - within the maximum period of stay, one extension of the contract with the same employer, as well as the conclusion of contracts with more than one different employer, may be allowed
 - re-entry of third-country nationals who return every year to the EU to do seasonal work can be facilitated (e.g. issuing several seasonal worker permits as a single administrative act).
- Labour rights and worker protection:
 - equal treatment with nationals of the host Member State, at least with regard to terms of employment, including the minimum working age, working conditions, in relation to pay and dismissal, working hours, leave and holidays, and health and safety requirements at the workplace
 - equal treatment with nationals also applies to certain aspects of social security (benefits linked to sickness, invalidity and old age), but excluding unemployment and family benefits due to the temporary nature of residence and employment
 - limited equal treatment with nationals in terms of tax benefits and education and vocational training is permissible
 - the right to join a trade union.
- Measures aimed at preventing possible abuses or sanctioning infringements and effective mechanisms for workers to lodge a complaint against their employer, either in person or through interested third parties.

Source: EUR-Lex, 2017; European Commission, 2016b; Council of the European Union, 2014.

Box 2.3. Some measures and initiatives in OECD countries to facilitate the selection of highly skilled migrants

In May 2016, the Council of Ministers and the European Parliament approved new conditions (replacing rules adopted in 2004 and 2005) of entry and residence of third-country nationals for the purposes of research, study, pupil exchange, remunerated and unremunerated training, voluntary service and au pair placements. Among others, researchers and students have the right to stay in the Member State where they completed their research or studies for a period of at least

nine months in order to seek employment or to set up a business. The right of students to work during their studies was increased from ten hours to a minimum of 15 hours a week.

Canada introduced “Express Entry” in 2015 for certain economic immigration programmes, including the Federal Skilled Worker Program, Federal Skilled Trades Program and Canadian Experience Class. Under the Express Entry system, the entry applications of those who score a high number of points for age, education, official language proficiency and work experiences and who hold a job offer are expedited.

To better target skills, Ireland modified the criteria and benefits of work permits for foreigners in 2014-15. The Irish “Green Card” became the Critical Skills Employment Permit and the work permit became the General Employment Permit. Lower salary thresholds were created for a number of categories of foreign workers, including graduates on a highly skilled occupation list.

Japan made adjustments to its points-based programme for highly qualified foreigners, reducing some of the eligibility criteria and granting indefinite leave to remain to certain highly skilled professionals.

The Republic of Korea significantly lowered the salary threshold required for foreign high-tech professionals to obtain a permanent visa. It is now equal to the average national salary, rather than three times as high. Other professional workers now have more opportunities to obtain a temporary visa in the Republic of Korea through the points system for foreign professionals, which allows faster access to permanent residency.

Source: OECD, 2016a, pp. 42–43.

2.3.4. DUAL APPROACH: RESTRICTIVE CONDITIONS FOR LOW-SKILLED MIGRANTS

Another example of an approach that treats highly skilled professionals and low-skilled migrant workers differently is Singapore, which is a prime Asian destination for international migrant workers, many of whom are domestic workers (box 2.4). Not only are the entry conditions for foreign domestic workers closely controlled, social integration into the national population is severely curtailed, in stark contrast to the treatment of foreign professionals in managerial, executive and specialized jobs.

One of the principal elements of migration policies directed at less-skilled migrants is limiting their entry in order to safeguard low-skilled jobs for local workers and to protect local wages (OECD, 2008b, p. 139; OECD, 2016a, p. 43). Towards this end, many countries implement labour market tests, points-based systems and quotas or caps (OECD, 2008b, p. 159). More restrictive entry conditions have been adopted recently in some OECD countries (box 2.5).

Another principal element of policies targeting low-skilled migrants is ensuring that their stay is temporary, thereby avoiding potential problems associated with their settlement, namely long-term employability, integration, impact on the host country’s labour market and public finances, and the educational and labour market outcomes of their children (OECD, 2008b, p. 126). A review of immigration routes available to low-skilled migrant workers in Australia, Canada, Hong Kong (China), Japan, New Zealand, Singapore, the United States and the United Arab Emirates shows that these routes tend to be temporary, without the opportunity for settlement (Lewis Silkin, 2016).

Because issuing a short-term visa or permit has not been enough to guarantee that a migrant worker leaves at the end of the period allowed by the permit, some temporary work programmes have developed features to address problems of high overstay rates (box 2.6). Bilateral agreements (discussed further in section 5) between origin and destination countries have also been used to

make the sending country an active stakeholder in ensuring that seasonal and temporary programmes function properly and in fighting undocumented migration. In return for access or quota allocations (reserved for citizens of certain countries), sending countries are encouraged to implement proper processes for the selection of candidates and to put collective pressure on participants to comply. For example, the Republic of Korea reviews its bilateral agreements with sending countries on the basis not only of cooperation, but also of overstay rates. Canada, France, Germany, Italy, New Zealand and Spain open their seasonal work programmes to specific countries, with which they collaborate and whose partnership is subject to review (OECD, 2008b, p. 136).

Box 2.4. Singapore: Work permit versus employment pass

1. Work permit (WP) – issued to foreign unskilled and semi-skilled workers

- Worker is allowed to work for the employer who applied for the WP and in the specified occupation of the WP.
- Duration of a WP is generally two years, renewable for a period of two years.
- Within seven days of the termination of employment, the employer should cancel the WP and repatriate the worker.
- The worker should reside only at the address set by the employer.
- For each non-Malaysian worker, the employer buys a security bond (up to 5,000 Singapore dollars (\$)), pledging to pay the Government said amount if the employer breaks the WP rules.
- For each worker, the employer pays a monthly foreign worker levy.
- A worker may not marry a Singapore citizen or permanent resident in or outside Singapore without the approval of the Singapore Government. This applies even after the WP is expired, cancelled or revoked.
- A worker should not get pregnant or deliver a child in Singapore during the valid period of the WP unless said worker is already married to a Singapore resident or permanent resident with the approval of the Singapore Government.
- Unlike holders of the employment pass, WP holders cannot get their family members to join them in Singapore and cannot apply for permanent residence in Singapore.

Source: Singapore Government, Ministry of Manpower.³⁷

2. Foreign Domestic Worker (FDW) – in addition to the above requirements:

- Employers of FDWs should send each FDW for medical screening by a Singapore-registered doctor every six months. This medical examination screens for pregnancy and infectious diseases, such as syphilis, HIV and tuberculosis.
- If the FDW does not pass the medical screening for any of the required tests, the employer must cancel the FDW's work permit and send him or her home immediately.

Source: Singapore Government, Ministry of Manpower.³⁸

³⁷ Ministry of Manpower website: www.mom.sg/passess-and-permits/work-permit-for-foreign-worker/sector-specific-rules/work-permit-conditions Last updated 18 July 2017 [accessed 2 Sep. 2017].

³⁸ Ministry of Manpower website: www.mom.sg/passes-and-permits/work-permit-for-foreign-domestic-worker/eligibility-and-requirements/six-monthly-medical-examination Last updated 17 May 2017 [accessed 2 Sep. 2017].

3. Employment pass (EP) – issued to foreign professionals

- Eligibility criteria include:
 - working in a managerial, executive or specialized job
 - earning a minimum monthly salary of \$3,600
 - holding an approved university degree, professional qualifications or possessing specialized skills.
- Duration of the EP is two years, renewable for a period of up to three years.
- EP holders who earn a minimum of S\$5,000 a month can get their family members to join them in Singapore through the “dependant’s pass” and “long-term social visit pass” programmes.
- Unlike in the case of work permit holders, the following conditions apply:
 - no foreign worker levy or quota
 - can change employer
 - no marriage restrictions
 - can apply for permanent residence.

Source: Singapore Government, Ministry of Manpower.³⁹

Box 2.5. Recent examples of more restrictive measures to limit entry of low-skilled migrants

New Zealand, where the labour market test is mandatory for low-skilled workers, now requires employers to engage with the Work and Income authority before submitting a work visa application. The Work and Income authority provides guidance, reduces uncertainty for employers and streamlines the visa application process.

Canada has introduced a cap on the share of employees who can be classified as Temporary Foreign Workers, to reduce employer reliance on the programme.

Sweden modified its procedures for work permit applicants, who must submit their employment letter to a local Swedish labour union for comment.

Australia adopted more stringent requirements in terms of English language proficiency and introduced changes to its labour market test coverage.

Source: OECD, 2016a, p. 43.

³⁹ Ministry of Manpower website. See: www.mom.sg/passes-and-permits/employment-pass/key-facts Last updated 16 August 2017 [accessed 2 Sep. 2017]; www.mom.sg/passes-and-permits/employment-pass/eligibility Last updated 29 March 2017 [accessed 2 Sep. 2017]; www.mom.sg/employment-pass/faq Last updated 29May 2017 [accessed 2 Sep. 2017].

Box 2.6. Examples of measures adopted by OECD temporary work programmes to prevent overstays of temporary migrant workers

For stable, predictable seasonal needs, employers are allowed to rehire seasonal workers that they have hired in the past, and returning workers enjoy priority access and an easing of bureaucratic procedures. Most programmes eventually see many of the same workers returning year after year, and successful programmes have incorporated the likelihood of repeat migration into their procedures.

Workers may be recruited on the basis of specific criteria that increase the likelihood of their returning to their country of origin. For example, in Spain, the seasonal work programme suffered from substantial overstaying in the early 2000s. The Spanish authorities, together with the Moroccan public employment service, began to recruit married mothers for seasonal work. This group has had very low overstay rates.

Employers of temporary workers are made more accountable for overstaying workers, and subject to sanctions. Measures include the following:

- Employers are required to post a bond which they forfeit in the event that a worker whom they have recruited fails to return home at the end of the contract.
- In Italy, Republic of Korea and New Zealand, the employer is liable for expulsion costs in the event of a worker overstaying.
- Spain penalizes employers whose workers have high overstay rates by denying their subsequent applications for foreign workers or reducing the number that they can hire.

Source: OECD, 2008b, pp. 125–159.

2.3.5. LOW-SKILLED LABOUR MIGRATION PROGRAMMES

In spite of restrictive conditions on the entry and stay of less-skilled migrants, a number of OECD countries have maintained regulated channels for the entry of low-skilled migrants for employment reasons, and some have offered new entry opportunities in order to address shortages in low-skilled jobs (OECD, 2016a, pp. 43–44). Germany recently activated a channel for labour migration – not subject to skill or educational requirements – for citizens of Western Balkan countries. From January 2016, those with a valid contract in terms of wage conditions can obtain a work permit, subject to a labour market test. The channel will remain open until the end of 2018. Japan is implementing the gradual introduction of a programme authorizing the employment of foreign domestic workers in certain areas. In two regions of Japan, families may now hire foreign domestic workers through agency schemes and subject to prevailing wage requirements. The Republic of Korea adjusted its management system for non-professional foreign workers to allow for changes in the quota distribution among firms and sectors. The labour market test requirement was also shortened from two weeks to one week for certain sectors.

Among EU countries, Italy and Spain have welcomed large numbers of migrants into domestic work, although both countries saw declines in the aftermath of the 2007/08 financial crisis (Castagnone et al., 2013; Arango et al., 2013). Nonetheless, Italy continued to set a relatively large annual quota for low-skilled migrant workers, mostly for the homecare and personal care sector (Pastore and Villosio,

2011).⁴⁰ The United States also admits a huge number of temporary workers in low-skilled jobs (160,706 for seasonal agricultural and non-agricultural jobs in Fiscal Year 2012), but their numbers are not much greater than those admitted for specialized jobs (135,991 in 2012) or employment-related permanent migrants (143,998 in 2012) (Wilson, 2013). In relative terms, however, large-scale temporary low-skilled labour migration programmes are currently most visible in the GCC countries and Asia, particularly Singapore and Hong Kong Special Administrative Region (China), which are major destinations of domestic workers. Further discussion on this subject follows in subsection 2.4 below and section 4.

2.4. MIGRANT CARE WORKERS

Because of the scarcity of global or regional data on the educational and occupational profiles of international migrants (noted in subsection 2.1), this particular section relies heavily on data from the OECD, which has produced relatively substantial comparative data on migrant teachers and migrant health workers in the OECD countries. To complement this partial picture, snapshots of the situation in non-OECD countries are drawn from available studies, some of which date back to the early 2000s.

2.4.1. TEACHING PROFESSIONALS

An analysis of the Database on Immigrants in OECD and non-OECD Countries for 2000⁴¹ by Education International (Caravatti et al., 2014) shows that foreign teaching professionals in the United States and other developed countries originated mostly from OECD countries (North–North and intra-OECD migration), countries with a shared colonial history (i.e. Commonwealth countries) and countries with a shared language (i.e. Anglophone).⁴² Teacher migration has been highly prevalent among countries with an education system based primarily on the English language, such as Australia, Canada, India, Jamaica, Malaysia, South Africa, the United Kingdom and the United States (Sharma, 2012, p. 265). Where English is not the primary language of instruction, teacher migration has occurred but at relatively less significant levels.

Foreign teaching professionals in Canada came principally from two countries, United Kingdom and the United States; in Australia, primarily from United Kingdom. Those in United Kingdom had more diverse origins, with the top ten countries of origin being, in order of importance, Ireland, Germany, France, India, the United States, Australia, South Africa, Canada, New Zealand and Pakistan. Foreign-born teachers in the United States also come from many countries: Mexico (a top source, providing 67,520 migrant teaching professionals in 2000), followed by China, Germany, India, Canada, United Kingdom, Puerto Rico, the Republic of Korea, the Philippines and Cuba in the

⁴⁰ The current quota system allows the entry (or conversion from one type of contract to another, such as from student to work permit) of 30,850 people for 2017 (Source: Governo Italiano, Ministero dell’Interno, www.interno.gov.it/it/notizie/decreto-flussi-2017-lavoratori-stranieri-stagionali-dal-21-marzo-precompilazione-domande [13 Mar. 2017]). About half of this quota is for conversion to another type of work permit for people already in regular migrant status in Italy, while some 17,000 permits are for seasonal workers from a number of countries with which Italy has signed a readmission agreement. Although the quota is relatively restrictive compared to the past, the channels for regular migration of low-skilled migrants have remained open throughout the years, even during the financial crisis of 2007/08 (Castagnone et al., 2013). Italy’s migration policy with regard to domestic workers is discussed further in section 4.

⁴¹ This database (DIOC-E2000) is the only comparable database on immigrant stocks broken down by occupation. It exists only for one point in time (i.e. national censuses carried out around 2000) and provides information on persons by country of birth and occupation.

⁴² The occupational category “teaching professionals” in the OECD database for 2000 is ISCO-23, which includes university and higher education teachers, vocational education teachers, secondary education, primary school and early childhood educators (including childcare centre managers), and other teaching professionals (including information technology trainers and private music, dance and arts teachers).

top ten origin countries. Between 2002 and 2008, thousands of teachers from the Philippines, India, and other countries were sought by employers in the United States, primarily to teach in urban school districts that had traditionally struggled to attract teachers (Caravatti et al., 2014, p. 16).

The international movement of teachers from developing countries to developed countries was so significant that it became the subject of international policy debate by the late 1990s. Attendees of Commonwealth education meetings, beginning in 1997, learned that large-scale teacher recruitment and migration was having a serious impact on the education systems of Barbados, Guyana, Jamaica and Trinidad and Tobago. Large-scale recruitment of teachers by the United States and United Kingdom had forced these island countries to compete for the best-qualified teachers (Caravatti et al., 2014). In 2001, the South African Minister for Education accused Britain of “raiding” its resources and, at the same time, ministers in Jamaica proposed that developing countries should receive compensation from the United Kingdom and United States for the loss of their teachers due to international recruitment practices (Appleton et al., 2006). Concern over the international recruitment of teachers at the Commonwealth Ministers of Education conference in Edinburgh in 2003 led to the Commonwealth Protocol on Teacher Recruitment in 2004, which laid out a series of measures and regulatory guidelines for recruiters, as well as rights and responsibilities of sending and recruiting countries, and of recruited teachers (Appleton et al., 2006; Caravatti et al., 2014).

There have been other migratory movements of teachers in other parts of the world. Census data from Costa Rica for 2000–11, disaggregated for foreign-born workers by origin country and occupational sector, showed that the country’s largest number of migrants in teaching professions (primary to university level) came from Nicaragua, with a net increase of 80 per cent over that period. This was consistent with Nicaraguans’ high share (75 per cent) among total immigrants in Costa Rica (Caravatti et al., 2014, p. 24). Between 1990 and 2000, teachers made up 15–27 per cent of Colombians who migrated to other countries in Latin America (Caravatti et al., 2014, p. 23). Their top destination, in total numbers, was Venezuela.

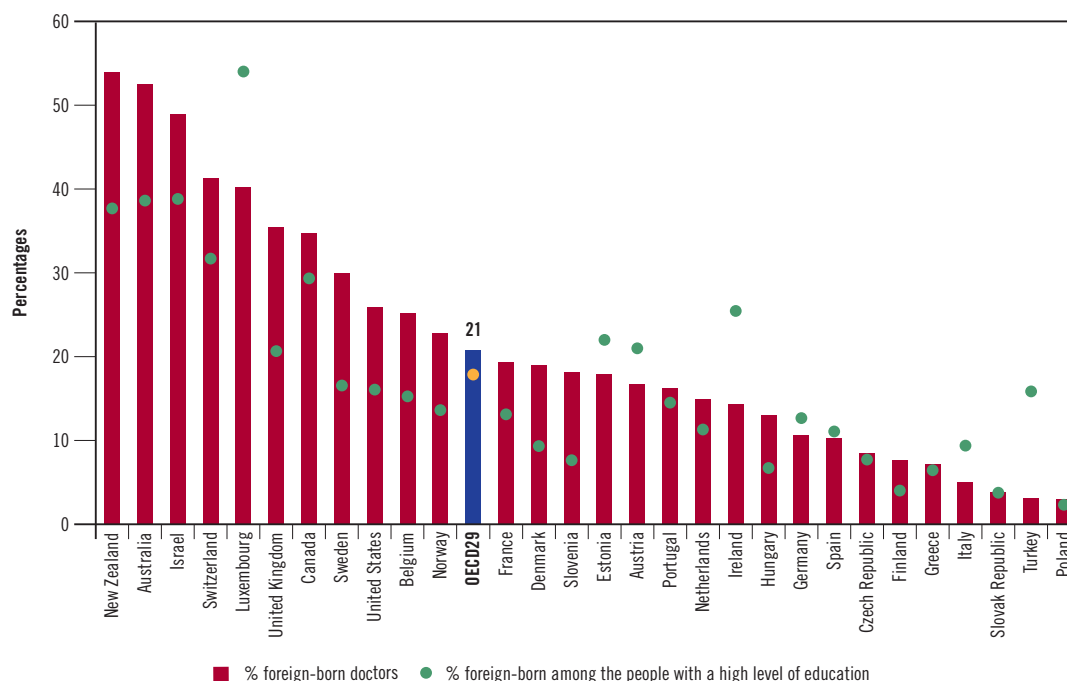
In the 1970s, when the Arab region saw substantial labour mobility after the oil boom, Jordan became a significant source of migrant labour for other Arab countries (Caravatti et al., 2014, p. 17). The expansion of higher education in Jordan created an excess supply of skilled labour that resulted in the migration of teachers to neighbouring countries. In the late 1990s, Ethiopia had to resort to recruiting international teachers from China, Cuba, Germany, India and the Philippines to meet teacher shortages resulting from rapid population growth (Caravatti et al., 2014, p. 17).

2.4.2. HEALTH-CARE PROFESSIONALS

In 2010/11, foreign-born doctors comprised an average of 22 per cent of all doctors across 22 OECD countries, and foreign-born nurses made up 14.5 per cent of all nurses (OECD, 2015, pp. 106–113; Dumont and Lafortune, 2016, pp. 5–11). These shares were significantly higher than the corresponding shares in 2000/01, when migrant doctors made up 19.5 per cent and migrant nurses, 11 per cent.⁴³ The share of foreign-born health workers in national health workforces varies widely between OECD countries. For example, foreign-born doctors accounted for more than 50 per cent of doctors in New Zealand and Australia but only 3 per cent in Turkey and Poland (figure 2.13). The share of foreign-born nursing professionals is over 30 per cent in New Zealand, Switzerland, Australia and Luxembourg but insignificant in Poland and Slovakia (figure 2.14). A small number of countries took

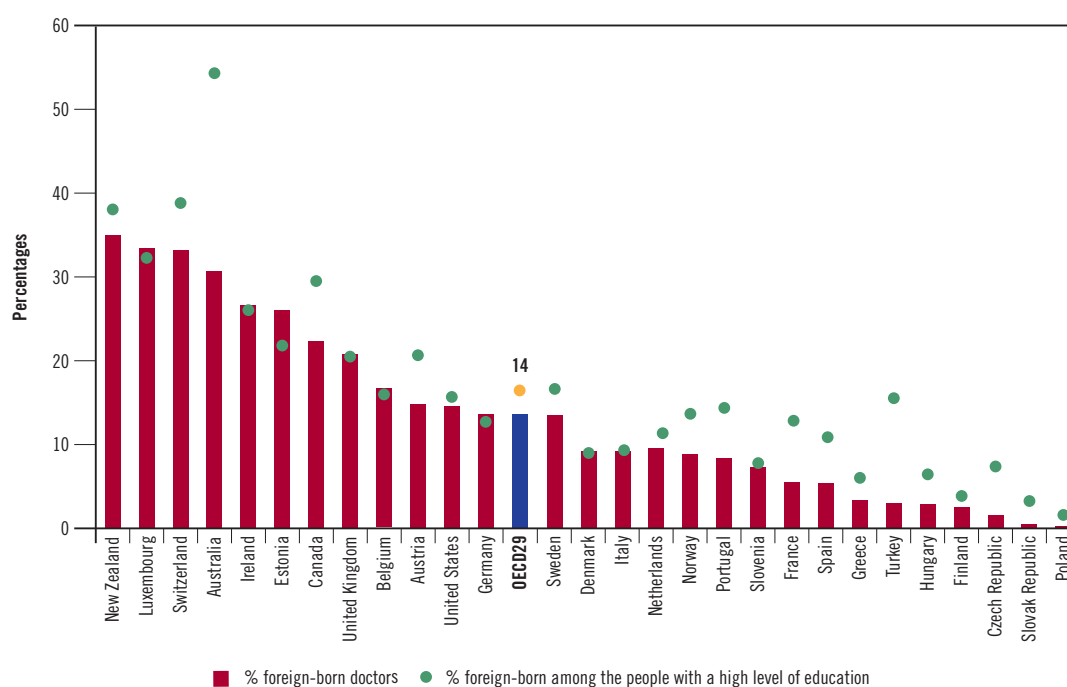
⁴³ Using population censuses and population registers circa 2000, the authors assembled information on people employed in health occupations by detailed place of birth for 24 OECD countries. Although these data have some limitations, the authors stated that they provide comparable estimates of the share of foreign-born health professionals in the total health workforce across OECD countries and of the distribution of health workers by country of origin (OECD, 2007b, p. 164).

Figure 2.13. OECD countries – Share of foreign-born among all doctors in the country, 2010–11



Note: The OECD average is the unweighted average for the 29 OECD countries presented in the chart. It differs slightly from the OECD total presented in Table 3.1 because the latter is a weighted average based on the 23 OECD countries for which data are available in 2000–01 and in 2010–11. Source: OECD, 2015, p. 111, figure 3.3.

Figure 2.14. OECD countries – Share of foreign-born among all nurses in the country, 2010–11

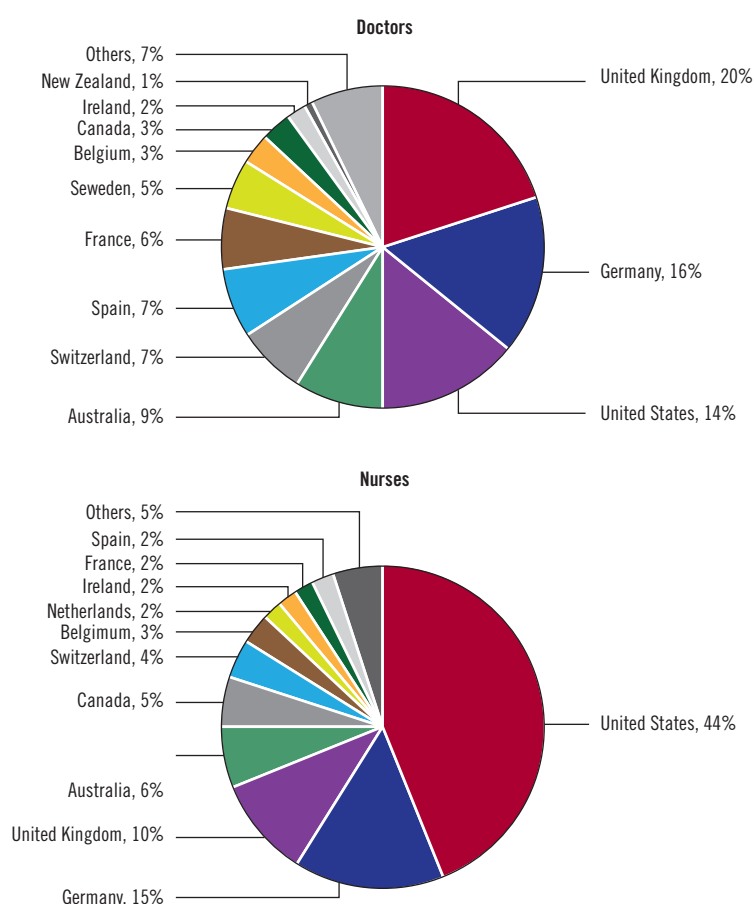


Note: The OECD average is the unweighted average for the 28 OECD countries presented in the chart. It differs slightly from the OECD total presented in Table 3.2 because the latter is a weighted average based on the 22 OECD countries for which data are available in 2000–01 and in 2010–11. Source: OECD, 2015, p. 111, figure 3.3.

the biggest shares of the growth in the total number of foreign-born doctors and nurses (figure 2.15). The United States received 44 per cent of the increase in foreign-born nurses. Along with Germany and the United Kingdom, these three countries took half of the increase in foreign-born doctors. Portugal and Greece, hardest hit by the 2007/08 economic crisis, registered significant declines in their shares of foreign-born health professionals. Foreign-born dentists and foreign-born pharmacists working in 16 OECD countries for which data were available, corresponded to 10.4 per cent and 12 per cent, respectively, of all professionals in their occupational category, with wide variation between countries (OECD, 2007b, p. 166).

India and the Philippines account for the largest shares of immigrant doctors and nurses in OECD countries by a significant margin. They were the two main sending countries in 2000/01, but their outflows grew considerably over the ten-year period. Between 2000/01 and 2010/11, emigration rates rose for both doctors and nurses such that by 2010/11, about 6 per cent of doctors and nurses in the world had emigrated to an OECD country (Dumont and Lafortune, 2016, p. 13).⁴⁴

Figure 2.15. OECD countries – Distribution of new foreign-born doctors and nurses by country of residence, 2000–01–2010–11



Note: Calculations based on the data by destination countries presented in Tables 3.1 and 3.2 for the comparison across time (excluding those countries where has been a decrease in the number of foreign born health personnel).

Source: OECD, 2015, p. 116, figure 3.8.

⁴⁴ See also Table 3 A1.1 in OECD, 2015, pp. 179-181. Expatriation rates calculated for countries for which data were available back to at least 2005. A total of 149 countries of origin for doctors and 141 countries of origin for nurses were included (Dumont and Lafortune, 2016, p. 13).

In Latin America and the Caribbean, available data from 2007 on 10 countries in the region indicated that the greater majority of professional nurses emigrating from these countries left the region; only some 9 per cent went to countries within the region (Organización Panamericana de la Salud, 2011, p. 15).⁴⁵ The most preferred intraregional destinations were, in the order of reported share of immigrant nurses: Brazil, The Bolivarian Republic of Venezuela, Chile and Argentina. More than 90 per cent of emigrating nurses went to the United States and Europe. Peru accounted for 95 per cent of emigrating nurses.

2.5. HOME-BASED CARE WORKERS: THE LESS VISIBLE SEGMENT OF CARE ECONOMIES

2.5.1. DOMESTIC WORKERS, PERSONAL AND HOUSEHOLD SERVICE WORKERS

Comprising the less visible (and often poorly regulated and poorly remunerated) segment of the care workforce are care workers who work in and for private households, looking after the needs of family members. The ILO refers to them broadly as “domestic workers” following the Domestic Workers Convention, 2011 (No. 189), which defines a domestic worker as “any person engaged in domestic work within an employment relationship”, where domestic work is “work performed in or for a household or households”. Under this broad term and definition, the tasks carried out by domestic workers can be wide-ranging, depending on the socio-cultural and economic situation of a particular area or country and the specific demands of private households. Tasks may include housework (cooking, laundering, house cleaning and collecting firewood for cooking), caring for children, frail, older, sick and physically disabled persons in private homes, and driving the family car, taking care of the garden and guarding private houses, all of which are generally considered to be “household work” or “personal care” (ILO, 2016a). Their employers may be private households, who hire them directly, or may be private or public agencies that hire them and deploy them to private households for specific services or tasks.

For the same set of tasks, the European Commission uses the term “personal and household services” (PHS in short), i.e. “a broad range of activities that contribute to well-being at home of families and individuals: child care (CC), long term care (LTC) for the elderly and for persons with disabilities, cleaning, remedial classes, home repairs, gardening, ICT support, etc.” (European Commission, 2012, p. 4). The European Commission characterizes PHS as involving: “varying levels of technical skills requirements (possibilities of “do it yourself” in some areas, higher requirements in the case of care), but generally a need for a decent level of e-skills and good relational and social skills; low productivity in some of the tasks involved”. Workers in the PHS sectors have been profiled as: “mostly women, mainly working part time, with relatively low skills, and often from migrant background” (European Commission, 2012, p. 13).

There are several categories of care workers that come under different names in various countries, but which have one feature in common – they provide direct relational (direct person-care) and non-relational (indirect person-care, household services) to private individuals in need of care. They are “nannies”, “home carers”, “social care workers”, “collaboratrice familiare” (in Italy), among others. Some are employed by agencies that deploy them to the private homes of care recipients; some are employed directly by care recipients or their families. Section 4 contains further discussion on the employment arrangements of these various types of home-based care workers.

⁴⁵ The report noted that because of the scarcity of systematic data collection on emigrant nurses, the figures cited may have underestimated the size of emigration.

For various reasons, including the informality of employment arrangements, national official labour force statistics tend to underestimate the number of workers employed by private households.⁴⁶ The *World Health Report 2006* points out that “available methods for identifying health workers exclude unpaid caregivers and volunteers and official counts often omit people who deliver services outside health organizations” (WHO, 2006, pp. 2).

The demand for paid home-based care has been driven by a combination of changes in demographic structures, women’s labour market participation, and attitudes and policies regarding non-familial care provision. Migration policies of both destination and origin countries have evolved to facilitate or shape the international movements of workers into home-based care and domestic work. In Europe, ageing populations who are living longer, policies encouraging women to participate actively in the economy, and the rising number of dual-earner families have combined with policies that enable families to hire or contract non-familial care workers through the market, and contributed to increases in the employment of migrant home-based care workers (Williams, 2012, p. 365). The combination of care and migration regimes is discussed further in section 4.⁴⁷ In East and South-East Asia, the recent increase in the migration of female domestic and care workers is related to the following changes: rapid demographic ageing and low fertility rates, and an increase in women’s labour market participation in richer countries; increased cultural acceptance and normalization of outsourcing family care to non-familial caregivers; and increased economic imperatives and incentives for women from less well-off countries to seek employment in other countries (Peng, 2017, p. 2). In the GCC countries, the rentier economy, the high social status accorded by employing a domestic worker to women who are not employed and a pervasive dislike for institution-based care for older relatives, drive the demand for low-cost, low-skilled domestic workers (Tayah, 2016, p. 30).

2.5.2. ILO GLOBAL AND REGIONAL ESTIMATES OF DOMESTIC WORKERS

According to the latest ILO global estimates, which are based on 2013 national official statistics, there are 67.1 million domestic workers in the world, of whom 11.5 million (one-sixth) are international migrants (ILO, 2015a). Considerable proportions of migrant workers are domestic workers in the Arab States, Asia and the Pacific and Latin America and the Caribbean (figure 2.16). In terms of the regional distribution of migrant domestic workers across the world, their top four destinations are the Arab States, Northern, Southern and Western Europe, South-East Asia and the Pacific, and Eastern Asia (figure 2.17). Migrant domestic workers are disproportionately concentrated in high-income countries: while accounting for a modest 21 per cent share of domestic workers (migrants and non-migrants) globally, these countries are host to nearly 80 per cent (9.1 million) of all *migrant* domestic workers.⁴⁸

Women comprise about 73.4 per cent (or around 8.5 million) of all migrant domestic workers. Domestic work is a much more important source of employment for female migrant workers than

⁴⁶ Other reasons for the under-reporting of home-based care workers are: undeclared workers, especially if they have irregular migrant status or have no work permits; unregistered with social security; non-compliance with labour standards; and workers being trafficked into employment. For example, in Germany, household surveys indicated that almost 1 million domestic workers work in the country but, in 2009, only 217,000 domestic workers were in formal employment and far fewer, only 36,056, had an employment relationship for which social security contributions were paid (cited in Tayah, 2016, p. 37).

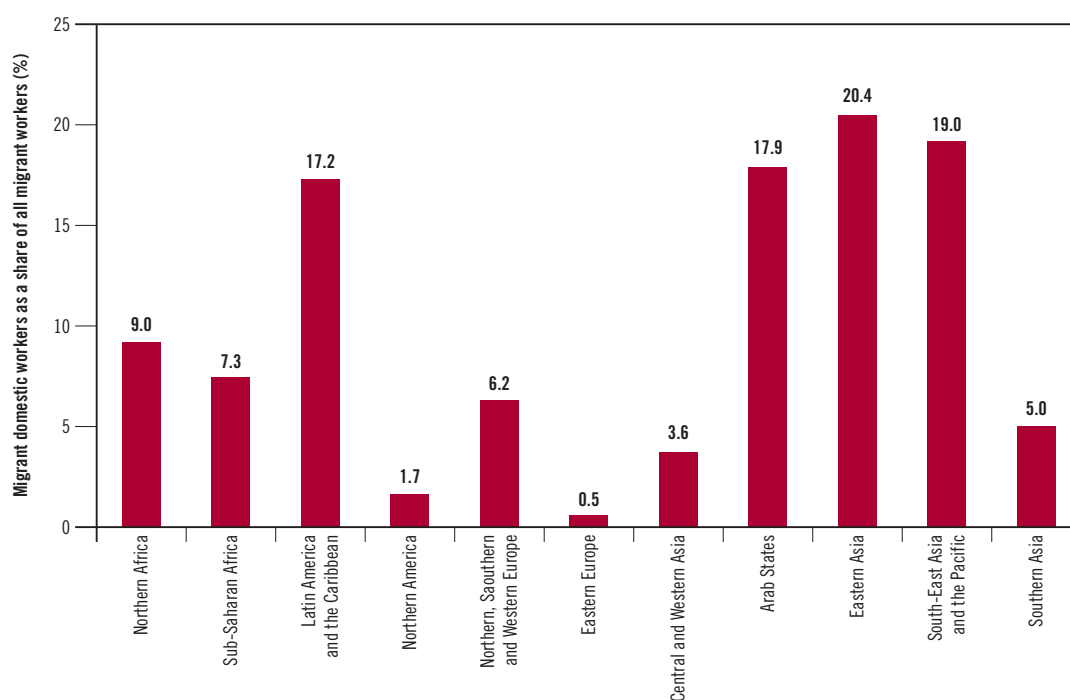
⁴⁷ A convergence of social policies, across the EU and the OECD, made the dual-earner (worker-adult) family model a part of its strategy to boost labour market self-sufficiency, economic competition and social inclusion. This meant greater public responsibility for addressing families’ (specifically women’s) care responsibilities and people’s care needs.

⁴⁸ A total of 66 per cent of domestic workers in high-income countries are migrants. In contrast, migrants account for only 6 per cent and 10 per cent of domestic workers in lower middle-income and upper middle-income countries, respectively. According to the ILO estimates, 74.7 per cent of migrant workers in 2013 were in high-income countries (ILO, 2015a).

for male migrant workers – 13 per cent of all female migrant workers are domestic workers while only 4 per cent of male migrant workers are engaged in paid domestic work.⁴⁹ However, there are significant gender differences at the subregional level (figure 2.18). In the Arab States, 10.4 per cent of male migrant workers are in domestic work. Viewed from another perspective, the Arab States host 50.8 per cent of all male migrant domestic workers across the world, but only 19 per cent of all female migrant domestic workers.

The principal origin countries for migrant domestic workers in the Arab States are the Philippines, Indonesia, Sri Lanka, India and Ethiopia, but new flows are coming from Nepal, Bangladesh and Madagascar (Tayah, 2016, pp. 32–37). In Asia, where the principal destinations are Taiwan (China), Hong Kong (China), Singapore and Malaysia, the main sources are the Philippines, Indonesia, Bangladesh, India, Nepal, Sri Lanka and, more recently, Viet Nam. With regard to Europe, geographic and historical relations determine the main migration channels. Latin workers seek employment in Spanish and Portuguese sectors, while Russian and Baltic workers tend to find employment in Finland. East–West migration within the European Union is a key characteristic of flows, with the exception of Ireland, Denmark and Sweden, which attract non-European domestic workers.

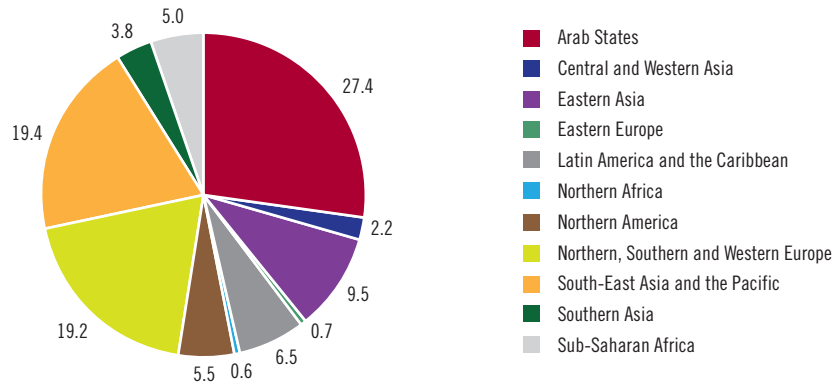
Figure 2.16. Migrant domestic workers as a share of all domestic workers, by broad subregion, 2013 (%)



Source: ILO, 2015a, p. 21, figure 2.23.

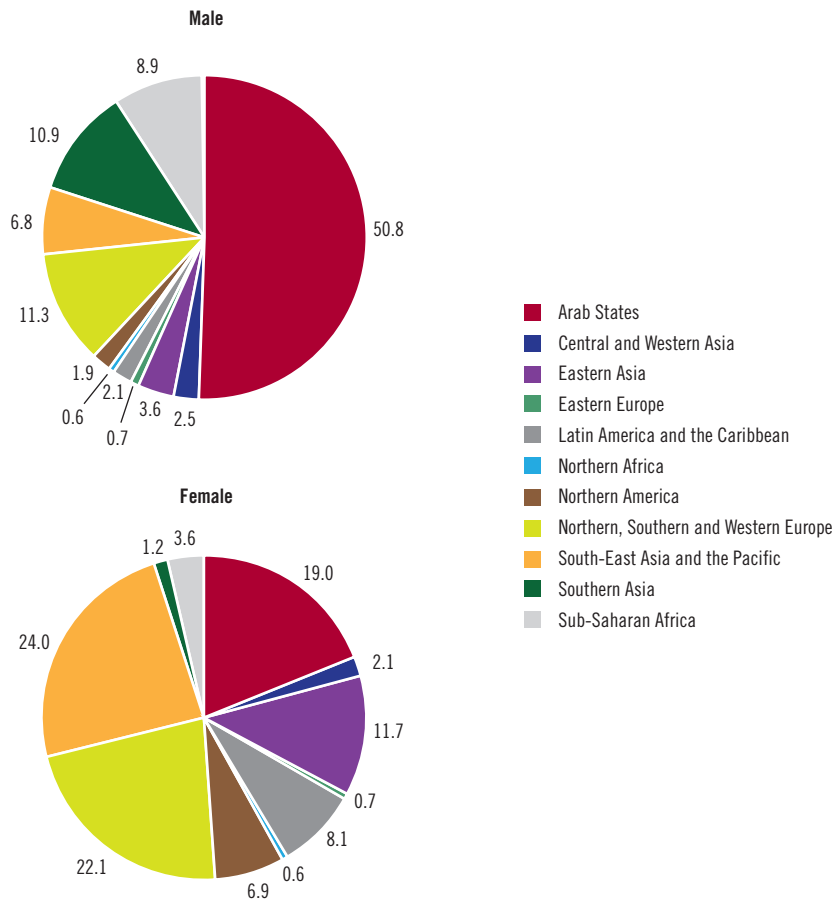
⁴⁹ Some 13.7 and 13.8 per cent of female domestic workers in upper middle-income and high-income countries, respectively, are migrants.

Figure 2.17. Distribution of migrant domestic workers, by broad subregion, 2013 (%)



Source: ILO, 2015a, p. 20, figure 2.21.

Figure 2.18. Distribution of male and female migrant domestic workers by broad subregion, 2013 (%)



Source: ILO, 2015a, p. 20, figure 2.22.

2.5.3. OECD ESTIMATES OF HOME-BASED CAREGIVERS

The latest data on OECD countries show that, for 2012–13, 28.5 per cent of home-based caregivers were foreign-born (OECD, 2015, p. 123). Home-based caregivers in this data set consisted of nurses, nursing aides and less-skilled carers who provide help in the home for older and disabled persons including in “activities of daily living, such as bathing, dressing, and getting in and out of bed” (OECD, 2015, p. 121). The share of foreign-born workers in all home-based care workers in a country varies across countries (table 2.1). Based on these OECD data, countries that rely most heavily on foreign-born workers for home-based caregiving (migrants make up more than 60 per cent of caregivers in the country) are Israel, Italy, Greece and Spain. In Slovakia, Hungary and Poland, most of the native-born care workers in households are cross-border workers who work in neighbouring countries (OECD, 2015, p. 122). Most caregivers in Israel come from East Asia and Eastern Europe. These figures are based on official sources, but there are many migrants who are undocumented or waiting to receive their papers.

Table 2.1: Home-based caregivers in the total labour force and share of foreign-born in selected OECD countries, 2012–13

Country of residence	Home-based caregivers in the labour force (%)	Foreign-born among home-based caregivers (%)	Top four countries of birth
Sweden	5.01	22.2	Iraq, Finland, Serbia, Iran
United Kingdom	2.70	18.8	India, Nigeria, Philippines, Zimbabwe
Slovak Republic	1.57	0.4	–
Netherlands	1.38	14.3	Morocco, Suriname, Germany, Indonesia
Italy	1.03	89.0	Romania, Ukraine, Moldova, Peru
Finland	0.92	–	–
Switzerland	0.80	20.1	Germany, Portugal, Kosovo, Italy
Belgium	0.79	14.6	–
Czech Republic	0.70	1.7	Slovak Republic
Austria	0.52	29.6	Romania, Slovak Republic
Estonia	0.49	4.5	Russian Federation
Norway	0.46	19.5	Somalia, Pakistan, Ethiopia, Germany
Spain	0.43	67.4	Bolivia, Ecuador, Romania, Colombia
Hungary	0.27	–	Romania
Slovenia	0.20	–	–
Luxembourg	0.19	50.0	–
Poland	0.19	1.6	–

Country of residence	Home-based caregivers in the labour force (%)	Foreign-born among home-based caregivers (%)	Top four countries of birth
Greece	0.09	74.5	Bulgaria
Portugal	0.09	–	–
Germany	0.08	10.8	–
Ireland	0.08	–	–
France	0.02	–	–
<i>European countries above</i>	<i>0.85</i>	<i>29.3</i>	Romania, Ukraine, Moldova, Poland
Canada	2.04	27.5	–
Israel	0.71	91.3	Asian countries (excl. former USSR Asian republics), former USSR (excl. Russia & former Asian Republics)
United States	0.37	25.1	Dominican Republic, Mexico, Jamaica, Haiti
<i>OECD</i>	<i>0.47</i>	<i>28.5</i>	Romania, Ukraine, Philippines, Dominican Republic

Notes: Data for Greece, Spain, Ireland, Israel, Italy and Portugal are underestimates because they include only caregivers directly employed by a household and exclude those recruited by a company to provide home-based care. Data on Canada are overestimates because they are not restricted to home-based care and can include other assisting occupations in support of health services. Data sources are: European countries - Labour Force Surveys (Eurostat) except Greece, Ireland, Italy, Portugal, Spain: 2012-13-14; Canada – Labour Force Survey 2012; Israel – Labour Force Survey 2011; United States – American Community Survey 2013.

Source: Extracted from Box 3.2. OECD 2015, p. 123.

2.6. DEMAND AND SUPPLY; PULL AND PUSH

The literature on migration of teachers, health workers and domestic workers provides substantial information on motivations and conditions that push or pull them to migrate to another country (Fleury, 2016, pp. 6–7; Aluttis et al., 2014, p. 3; WHO, 2006, pp. 98–101; Edwards, 2014, pp. 30–31). Various financial, professional, political, social and personal circumstances act as both push and pull factors that contribute to their decisions to migrate. In general, a better livelihood and life for themselves and their families are at the root of decisions to migrate. This is typically provoked by dissatisfaction with existing working and living conditions, and awareness of the existence of (and desire to find) better jobs elsewhere. For example, a study of reasons to migrate among health workers in Cameroon, South Africa, Uganda and Zimbabwe in 2004 pointed to the following push factors: lack of promotion prospects, poor management, heavy workload, lack of facilities, a declining health service, inadequate living conditions and high levels of violence and crime (Awases et al., 2004, cited by WHO, 2006, pp. 98–101). Epidemics of HIV/AIDS and other serious illnesses contribute to making work stressful in developing countries. Better job prospects overseas, higher levels of remuneration, opportunities for upgrading qualifications and gaining experience and a safer environment are major pull factors. The same WHO report (2006) noted that, in Zimbabwe, 77 per cent of final year university students were being encouraged to migrate

by their families. A survey of undergraduate medical and nursing students in Nepal revealed that 50 per cent planned to migrate because of the better prospects in terms of salary and living and working conditions elsewhere (ILO, 2017a).

Civil war and conflict, political instability and food insecurity have played a role in decisions of some care workers to leave their country of origin. Penson et al. (2011) discuss the challenges faced by teachers forced to leave countries in conflict, and look at the specific issues of South Sudanese refugee teachers in Uganda and Zimbabwean refugee teachers in South Africa.

Beyond individual and family motivations, the accelerated rate of globalization of the service sector over the past two decades has driven labour migration. Policies and programmes in destination and origin countries have driven migration flows. This is demonstrated by the massive migration flows occurring in older person care, childcare and domestic work. The expanding unmet demand for these workers in high-income countries has led many states in Asia and Africa to embark on explicit policies and strategies for training and deploying care workers for overseas jobs. A huge industry of professional recruitment and employment agencies in destination and origin countries actively sources and deploys workers internationally. Recruitment of skilled teachers and health professionals from developing countries was on such a massive scale in the 1990s and 2000s that several codes of practice for fair recruitment have been adopted by various organizations (see section 5 for more information).

Looking more closely at the migration of workers into the health-care sector of OECD countries, shortages in health-care workers were a major driver of demand. In the late 1990s and early 2000s, several OECD countries expressed concerns over emerging shortages of health workers, especially doctors and nurses, in the face of increasing demand from an ageing population that was also living longer, declining ability and willingness of families to provide unpaid child and older person care, the declining share of the working-age population and rising incomes (OECD, 2008a). The need for long-term care⁵⁰ was seen as particularly challenging. In the United Kingdom, during the mid-2000s, projections for future demand for long-term care estimated that expenditure on social care would have to double between 2007 and 2032 to meet the increased demand for social care and rising real unit costs of care. The model also projected that the social care workforce caring for older people would need to increase by 79 per cent (Shutes, 2011, p. 3).⁵¹ Alongside expanding care needs were health-care labour shortfalls, which were traced to several factors, including underinvestment in medical education and public policies designed to constrain health-care costs.⁵² Moreover, there were increasing difficulties in recruiting and retaining native-born care workers.⁵³ These staff shortages were projected to increase in the near future. One recognized route to partially overcome these shortages was recruitment of international migrant workers.⁵⁴ In several OECD countries, immigration jumped

⁵⁰ Long-term care encompasses medical care as well as help in the house for older and disabled persons in “activities of daily living, such as bathing, dressing, and getting in and out of bed, which are often performed by family, friends and lower-skilled caregivers or nurses”, which are referred to as “social care” in the United Kingdom.

⁵¹ Wittenberg et al., 2010, p. 15 cited in Shutes, 2011.

⁵² Especially in OECD countries, the local nursing workforce has failed to keep up with growing demand for health care (Yeates, 2017, p. 540). Measures to contain costs have led to insecurity to nursing jobs, recruitment freezes, redundancies, limitations on number of nurses being trained, and poor pay and working conditions. For example, in Australia, Canada, Ireland, New Zealand and the United Kingdom, shortfalls in the number of nurses had been attributed to the long-term effects of financial underinvestment in education and training for nurses.

⁵³ The latter has been widely attributed to the low pay, long working hours, unfavourable shifts, low status and poor career mobility experienced in the sector (OECD, 2007b; Cangiano et al., 2009).

⁵⁴ In spite of policy recognition and commitments to increase take-up of medical training and adopt measures to improve the retention of national workforces, efforts were insufficient to address the issue. Staffing needs were immediate but human resources development has a lag time and is costly. Also note that immigration numbers tend to rise and fall (as immigration controls relax and tighten) with the state of the economic growth of a country.

sharply at about the time that such shortfalls were identified at the end of the 1990s (Yeates, 2017). In the United Kingdom, intensive recruitment of migrant health professionals occurred in the early 2000s, when rapid expansion of the country's health-care staffing was sought over a short period of time (Cangiano et al., 2009).⁵⁵ In the past decade, a number of OECD countries have stepped up the hiring of foreign workers (OECD, 2015, pp. 121–122).

⁵⁵ Such recruitment also occurred in the 1950s, when the country's ambitious universal health-care system was being established while costs were also being constrained.

3

CONCEPTUAL FRAMEWORK: UNDERSTANDING MIGRANT CARE WORK

Why do migrant workers play a more significant role (are more present) in the provision of care services in some countries and in certain contexts or segments of care economies but not in others? This section presents a framework for understanding the role of migrant labour in the provision of care: basic concepts of care work (subsection 3.1); the architecture of care provision and how care funding and delivery may be distributed among key actors, the family, the state, private for-profit and non-profit sectors (subsection 3.2); the underlying social and gender-based process of care work (subsection 3.3); and, finally, the three intersecting regimes – of care, migration and employment – that produce and shape paid care arrangements, including the employment and working conditions of migrant care workers.

3.1. CARE WORK

For this paper, *care work* is defined broadly as consisting of activities and relations involved in meeting the physical, psychological and emotional needs of adults and children, old and young, frail and able-bodied.

This broad concept of care work is consistent with the literature. England et al. (2002, p. 455) define care work as “occupations in which workers are supposed to provide a face-to-face service that develops the human capabilities of the recipient”. By “human capabilities”, they mean “health, skills, or proclivities that are useful to oneself or others”, which include “physical and mental health, physical skills, cognitive skills and emotional skills”. Similarly, Standing defines care work as “the work of looking after the physical, psychological, emotional and development needs of one or more other people” (Standing, 2001, p. 17).

Two broad kinds of care activities have been defined: first, those that consist of *direct, face-to-face, person-care activities* (sometimes referred to as “relational” care), which typically include the work of nannies, childcare workers, nurses, doctors, teachers, caregivers in nursing homes for older persons and older person caregivers in private households; and, second, those that *do not entail face-to-face person-care*, such as cleaning, cooking, laundry and other household maintenance tasks, sometimes referred to as “non-relational” care (Razavi, 2007, p. 8; Razavi and Staab, 2017). As Razavi notes, care work should not be limited to the tasks of directly caring for another person; it includes “activities that provide the preconditions for personal caregiving, such as shopping and preparing food and cleaning and washing clothes, sheets and dishes—work that is often done not

just for the person in one’s care, but also for the entire household” (Razavi, 2007, p. 8). Lutz makes a similar differentiation but uses the terms “person-related tasks” to refer to social support and care services addressing the needs of children, older and sick persons, and “object-related domestic tasks” to refer to cooking, cleaning, laundry and similar tasks (Lutz, 2011, p. 7). These two broad types of care activities cannot be divorced from each other. In practice, non-relational care and direct person-care intermingle. For example, domestic workers, generally defined as those who work for and in private households,⁵⁶ quite often perform non-relational or non-direct care tasks while also minding young children and/or taking care of older household members. Care work performed in the private household often consists of combined and overlapping elements of these two types of activities.

Care work is not limited to the care of frail older persons and those with illnesses and disabilities, although this is a commonly held notion because these persons often require intensive or specialized care. However, able-bodied children and adults also have physical, psychological, cognitive and emotional needs that require attention and care.

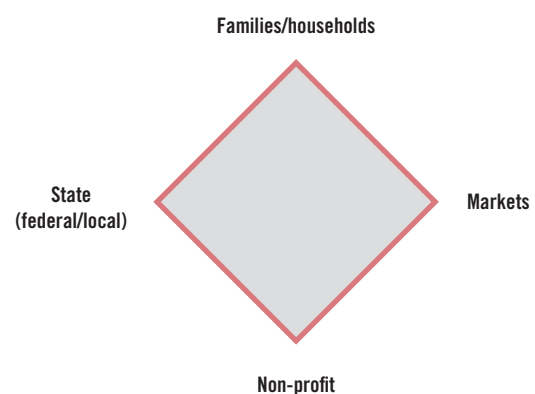
Care work can be paid or unpaid. *Unpaid care work* is care of persons for “no explicit monetary reward” (Razavi, 2007, p. 6). The largest amount of unpaid care work in nearly all societies takes place within households, most often carried out by women and girls. But individuals also perform unpaid care for people outside their families, such as friends, neighbours and community members, and within a variety of institutions (public, market, non-profit, community) on an unpaid or voluntary basis. *Paid care work* is care work performed in exchange for payment or remuneration in cash or in kind, and may be performed within a range of institutional settings, such as private households (as in the case of domestic workers), and public or private hospitals, clinics, nursing homes, schools and other care establishments. Paid care workers may be in an employment relationship, where the employer may be a private individual or household, public agency, a private for-profit enterprise or a private non-profit organization; or they may be working on their own account (self-employment).

3.2. INSTITUTIONAL ARCHITECTURE OF CARE PROVISION

3.2.1. THE “CARE DIAMOND”

The “care diamond” (figure 3.1), introduced by Razavi (2007, pp. 20–21), proposes a way of conceptualizing the institutional architecture through which care is provided – the four institutions, which are the family/household, the state, the market and the non-profit sector, which includes voluntary and community organizations; and the division (and redistribution) of care labour, cost and responsibility among them.⁵⁷ One can characterize societies in terms of the distribution of care provisioning across these institutional sites, and the roles of each of these institutions in delivering and funding care services. The boundaries between these

Figure 3.1. Care diamond



Source: Razavi, 2007, p. 21, figure 1.

⁵⁶ Definition taken from Domestic Workers Convention, 2011 (No. 189).

⁵⁷ The diverse range of public policies and institutional arrangements in care provisioning in welfare states has prompted various terms and schemas to show the roles of the state, family, market and private sector, and to typologize modes of caring (Razavi, 2007, pp. 20–21).

institutional sites are not clean-cut or static. The division of responsibility may vary depending on the care recipient and care domain concerned; for example, childcare versus older person care, or health care versus childhood education. Care services may be delivered by one institution but funded by another. As the discussion in this section and section 4 will elaborate, the institutional site of care provisioning has important implications for who can access adequate care and who bears the cost of care, and, most relevant to this report, for the employment situation of paid care workers and the role of migrant care workers.

In all societies, in both developing and developed countries, the main bulk of care has been provided by the family or household on the basis of kinship and family relations, without pay or explicit monetary reward.⁵⁸ Women typically spend disproportionately more time on unpaid care work than men, across different regions, socio-economic classes and cultures (Ferrant et al., 2014; Razavi and Staab, 2008; Folbre, 2006; Lewis, 2001). The “male breadwinner” ideology, in which the principal role of men is to engage in paid work and earn, while that of women is to take care of the family, remains the dominant normative construct of gender relations around the world in spite of high or rising rates of women’s labour market participation. Thus, in addition to their paid work, women are said to work a “second shift” or experience a “double day”.

There are, nonetheless, variations in the patterns of time allocation in unpaid care. For example, women living in tightly knit rural communities may enjoy assistance from other female family members, while recent migrants to urban areas may have less access to such forms of informal assistance. Rural women might have to spend more time on household chores, in the absence of piped water and electricity, compared to their urban counterparts. Where public policies support childcare or older person care (e.g. paid parental leaves, public crèches), women may be able to reduce the time devoted to some of their unpaid care tasks. Relatively high-earning women are often able to outsource their domestic tasks to non-familial persons (often women) or purchase substitutes for time they would otherwise have devoted to housework or childcare (e.g. hiring a domestic worker or nanny, putting one’s child into a crèche).⁵⁹ By contrast, low-earning women typically have less financial flexibility to do the same and, in the absence of public or affordable care substitutes, would work the double shift.

There are also socio-economic forces that are eroding the readiness of family members to provide unpaid care. Women’s preferences are changing. Young girls have increased their participation in schooling, women are pursuing higher education and their employment rates have risen – leaving less time for unpaid housework and person-care. In a context of economic crisis, all household members – female, male, young, old – may have to take on paid work to compensate for job losses and augment household incomes. In poorer countries, unemployment and poverty have pressed increasing numbers of women into assuming greater breadwinning roles, without any form of state support for unpaid care work. Family ties and structures have also changed – households have become smaller and the number of extended families living under one roof has decreased; more families are headed by single parents; women marry later and bear fewer children.

As a result of combinations of the socio-demographic and economic factors mentioned above, the demand for care services that are “non-familial” (not involving family members) has been on the rise and employed care workers comprise a growing segment of the paid labour force. Care providers in the private sector comprise several kinds (further in section 4). They may be enterprises that

⁵⁸ Unpaid does not suggest that unpaid care carries no financial costs. It imposes costs on those who provide it in the form of lost opportunities, forgone earnings and financial obligations. These costs are unequally borne by those who carry the disproportionate burden of unpaid care, i.e. mostly female members of the family and community.

⁵⁹ In a context of high income inequality and high poverty levels, families living in poverty provide a steady source of cheap care labour.

organize and provide care services by care workers employed by the enterprises themselves; or that act as intermediaries, subcontracting care workers or establishments for and on behalf of care recipients; or that simply recruit care workers for private households, individuals or establishments. Care providers may also be own-account (self-employed) workers who provide services directly to private individuals and households, or who are subcontracted by intermediary agencies. The terms of triangular relationships that involve care recipients, care workers and these various types of establishments may be quite varied from country to country, and are evolving.

The role of markets in delivering care to individuals and families has expanded (as will be seen in section 4). This “marketization of care” has manifested itself in three main forms: (i) individuals and their families that directly purchase care services (e.g. private crèche, private nursing home) or employ care workers (e.g. live-in domestic worker) and privately finance the cost of these services; (ii) government care agencies that contract out to private establishments the delivery of publicly funded care services (privatization of care provision); and (iii) partial private financing of public care services, including through user fees and other extra monetary support from care recipients (Shutes and Chiatti, 2012; Morel, 2007; Da Roit and van Bochove, 2017). The care service can take place in a private or public establishment, as well as in a private family setting. Some market-based instruments entail “unburdening the family” or “de-familialization” of care responsibilities, such as when subsidized private crèches take over childcare (Clasen et al., 2007, p. 11; Adamson and Brennan, 2016 p. 5. Other measures involve a “re-familialization” of care (bringing care delivery back within the family setting), such as cash-for-care allowances that enable or encourage families to hire caregivers who provide care at home (e.g. a nanny at home rather than putting a child into a crèche; an older person care assistant at home rather than placing a frail older person into a nursing home).

The role of the voluntary, non-profit sector, such as charitable, religious and community-based organizations and individuals may be of particular relevance in many developing countries, where public care services are inadequate and resource-poor and private care services are unaffordable and inaccessible to the wider population. Charitable and religious-based care organizations also operate in developed countries, such as Italy and Germany (Castagnone et al., 2013; Lutz and Palenga-Möllnbeck, 2011).

The state plays a qualitatively different role from that of the other institutions. It is not only a direct provider of care services (e.g. public schools and hospitals; cash-for-care allowances), but also a significant decision-maker regarding the responsibilities to be assumed by the other three sets of institutions. It can also establish a regulatory framework, consisting of laws and regulations setting standards of acceptable behaviour by individual providers and recipients of care, and standards and rules for institutions and agencies that have direct roles to play in care provisioning; decide what, if any, care services and income transfers to support care should be provided; create institutions for care provision; and provide a framework for the development and supply of the care workforce (Standing, 2001, pp. 21–23).

Public policy on care reflects important societal changes. It brings into the public sphere care activities and relations traditionally treated as belonging within the family walls, as private. It can alter the division of labour, cost and responsibility among family, the state, market and voluntary or non-profit sector (Daly, 2001). At the same time, public policy reflects dominant normative frameworks and societal arrangements. The way in which public policy treats and organizes care provision reveals important dimensions of gender relations and women’s lives in respect of care, unpaid care and paid work, while capturing the properties of societal arrangements concerning personal needs and welfare (Daly, 2001, p. 36; Lewis, 2001).

3.2.2. TYPES OF CARE

In light of the above, it is clear that care provision and services may vary in any of the following dimensions: the institutional setting and social domain in which care is performed (e.g. the home, public sector, private sector, voluntary sector); the identity of the care provider (family, state agency, private enterprise, voluntary organization, etc.); the identity of the care recipient (e.g. child, older person, person with disability, adolescent, etc.); the social content of the care given; the relationship between the care recipient and the care provider; and the economic character of the relationship and the labour involved (e.g. paid or unpaid, employment relationship or other arrangement) (Thomas, 1993, cited by Daly, 2001, pp. 34–37).

Taking any of the above dimensions, frequent distinctions have been made, namely, between paid and unpaid care, between formal care and informal care, private home and institutional settings, and between care provided by the state or through the market. Unpaid care tends to be performed by a member of the family, relative or neighbour and performed in the home, while paid care is usually associated with a professional care worker and an institutional setting. Formal care is often associated with institution-based, regulated and paid care services, while informal care is associated with unpaid care, absence of state regulation and a home setting, although informal care and employment arrangements are known to exist in formal establishments and formal arrangements in home-based work.

The lines between these dichotomies can be fuzzy. It is very possible that care work performed inside the home is paid and regulated by the state. For example, in the United Kingdom, nannies are regarded as “qualified childcare professionals” akin to formal carers (with special training and required to register) but are based in the private home (Adamson and Brennan, 2016 p. 4). There are also countries where public funding is extended to both formal and informal forms of care. Canada’s childcare benefits provide examples: Care Expense Deduction (CCED), established in 1971, subsidizes both regulated (formal) and unregulated (informal) early childhood care and education; and Universal Child Care Benefit (UCCB), a flat rate, non-means tested taxable, benefit of CAN\$160 per month (as of 2015) to all families with children aged six and under (Adamson and Brennan, 2016, p. 10).

3.3. CARE WORK AS A SOCIAL PROCESS

In order to understand the employment situation of migrant care workers, it is important to bear in mind that care work is not only a set of tasks or activities. It is a network of relationships between the individuals and institutions involved in caring for the needs of individuals and families. These individuals and entities include the person who needs care; the family members and kin of the person who needs care and their organizations; care workers and their organizations; government agencies, which provide and/or support care services and regulate care provisioning; private for-profit and non-profit providers of care services, and the organizations and representatives of these providers. These social relations and care activities take place, are assigned and are carried out within normative, socio-political and economic frameworks (Daly, 2001, p. 36). Formal regulations (policies and laws) as well as social norms define the obligations and responsibilities for providing care and facilitating the provision of care, the rights of individuals and families to receive care as well as rights of individuals to perform care work.

3.3.1. GENDER-BASED NORMS PERMEATING CARE WORK

Under the male breadwinner ideology, society is divided into two domains which are differentiated by gender. The private domain (the home) is equated with unpaid care and women’s responsibility.

The public domain is equated with paid work, the workplace, the commodity economy and men's role. The workplace earns, and is thus regarded as "productive" and economically valuable, while unpaid caring is essentially regarded as a consumptive role and therefore viewed socially as "unproductive". Paid work enjoys high public esteem, while caring for one's family has little public value in a monetized world, although it may be (as it is to most) intrinsically satisfying and emotionally rewarding.⁶⁰

The System of National Accounts (SNA) classification of economic and non-economic activities had long perpetuated and reinforced the notion that unpaid care work is "unproductive" (Razavi, 2007). The SNA 1993 classified unpaid work, which was defined as consisting of household maintenance, cleaning, washing, cooking, shopping, providing care for infants and children (active and passive care), caring for the permanently ill or temporarily sick (as well as for older relatives and the disabled), and all volunteer work for community services, as lying "outside the SNA production boundary" and referred to it as "non-economic". It is only recently, with the adoption of the Resolution of the 19th ICLS on "Statistics of work, employment and labour underutilization" in 2013, that unpaid care work is explicitly recognized as part of "own-use production work" within the production boundary of the SNA (ICLS, 2013, pp. 2-3).⁶¹

Thus, historically and traditionally, care work is associated with women's unpaid work in the house (social reproduction), with women's inherent nature and with tasks that family members do without pay and without special training. The gendered division of labour is reflected in paid care work as it is in unpaid care work. In the same way that women provide the bulk of unpaid care work, women comprise the overwhelming majority of care workforces – teachers, nurses, childcarers, older person caregivers, etc. Jobs in health care, education and public social services are women's principal entry points into the labour market. Women also make up 80–90 per cent of domestic workers (ILO, 2015a; ILO, 2013).

3.3.2. UNDERVALUATION OF CARE WORK

These gender-based constructions of care work undervalue paid care work. Not least among them is the notion that caring is altruistic and intrinsically fulfilling, and that monetary rewards are, or should be, of secondary importance. Emphasis on financial compensation might attract the wrong kind of care worker, i.e. one who values material rewards more than the well-being of the person being cared for. Paying higher wages to care workers could threaten people's access to care when they need it. The principle of equal remuneration for men and women for work of equal value set out in the Equal Remuneration Convention, 1951 (No. 100) also applies to care work, including domestic work. Particular attention should be given to ensuring that domestic work is not undervalued due to gender stereotypes (ILO, 2012, para 707).

England et al., (2002, pp. 456–458) identify two features of care work which keep the wages of paid care workers low: the economic dependence of people who need care; and the labour intensity of care work. On the first point: people who need care often have little or no ability to pay for it – for example,

⁶⁰ The branding of household work as "unproductive" is traced to Adam Smith and Karl Marx, who supposedly shared contempt for "menial servants" and despised their toil as "parasitical, actually a kind of perversion of labor, as though nothing were worthy of this name which did not enrich the world" (Arendt, 1998, pp. 85-86).

⁶¹ Work is defined as "any activity performed by persons of any sex and age to produce goods or to provide services for use by others or for own use". Own-use production work includes: "(i) household accounting and management, purchasing and/or transporting goods; (ii) preparing and/or serving meals, household waste disposal and recycling; (iii) cleaning, decorating and maintaining one's own dwelling or premises, durables and other goods, and gardening; (iv) childcare and instruction, transporting and caring for elderly, dependent or other household members and domestic animals or pets, etc.". ICLS, 2013, pp. 2-3.

children, persons with disabilities, older persons and those who are sick. In the absence of affordable public care systems, low-income households could face difficulties in meeting the care needs of family members. When care is provided by paid workers, a third party (typically family members or the state) would have to pay for the care. But the third party's capacity and willingness to pay depend on their affluence and altruism, the prevailing norms and values concerning caring for others and, in the case of publicly funded or provided care services, the outcome of political negotiations between different interest groups and care needs. On the second point: person-care requires, essentially, face-to-face and sometimes hands-on contact, which cannot simply be replaced by productivity-enhancing technologies in the same manner as in manufacturing, for example. Care services are inherently labour-intensive, so raising the cost of labour would directly raise the cost of care at an almost equal rate. Rising costs of care might be beyond the capacity (or acceptable threshold) of those who need care and/or of the entity which pays for the care. In such a situation, care recipients will either go without care that could have been afforded at lower cost or choose an inappropriate type or lower quality of care, or care workers will work for wages that are not commensurate to their skill and the requirements of the job or for substandard wages.⁶²

Studies have documented the wage disadvantage suffered by care workers in comparison to other workers with comparable skill levels in non-care related occupations (Razavi and Staab, 2017). An empirical analysis by England et al., (2002) of person-care jobs in the United States showed that just being in a care job, taking other personal and job characteristics as constant, resulted in a wage 5–6 per cent lower than that of other workers in a non-care job – a wage penalty for care work.⁶³ The same workers (i.e. holding individual characteristics constant) generally experienced a decline in wage when entering a care occupation and an increase when leaving care jobs. The relative penalty could not be explained by low unmeasured human capital or a disinclination to bargain for high pay among care workers – personal characteristics which presumably affected workers' pay in all jobs they took on. In addition, the statistical analysis showed that the wage penalty could not be explained solely by the predominance of women in care jobs, location in marginal industries or in the public sector, the fact that they were often not unionized, the low cognitive or physical demands of the jobs, or low levels of education and experience among care workers.

The Domestic Workers Convention, 2011 (No. 189) specifically requires ratifying States to take measures to ensure that domestic workers enjoy minimum wage coverage, where such coverage exists, and that remuneration is established without discrimination based on sex.⁶⁴ Budlender's analysis of domestic workers' earnings in relation to earnings of other wage workers of the same sex, population group, education level, skill level, age and status of employment in South Africa showed that a domestic worker, by virtue of the occupation alone, earns 13.6 per cent less than other employees (Budlender, 2011).⁶⁵ In the Philippines, a domestic worker, by the fact of her/his

⁶² Other sectors can source wage increases from productivity gains resulting from technological advances and economies of scale, but such productivity gains are much more limited in the care sector.

⁶³ England et al., (2002) used US pooled panel data from 1982–1993 waves of the National Longitudinal Survey of Youth, a national probability sample of individuals aged 14–21 in 1979, with over-sampling for blacks and Latinos. Respondents were interviewed annually. The sample was limited to those who were employed part- or full-time during at least two of the years in the period 1982 to 1993. Because the same people were surveyed year after year, the fixed-effects model was used. Fixed-effects analysis used persons as their own controls, taking wage changes as individuals move into and out of care work as the basis for the estimates of the penalties for doing this kind of work. Coded care occupations were doctors and other medical professionals, teaching professionals from higher education to primary education, childcare workers and other social care workers. The following limitations apply: (i) age restrictions were an obvious limitation since respondents were aged 14–21 in 1979, therefore the oldest were 35 in 1993; (ii) the sample shows only early careers – if care workers receive higher pay increases with age or experience, then the pay penalty is overestimated; (iii) the sample under-represents immigrants in the later survey years as the numbers of immigrants have increased dramatically since 1980.

⁶⁴ Convention No. 189, Art. 11

⁶⁵ Budlender carried out a regression of log hourly earnings using South African Labour Force Survey (September 2007) data.

occupation alone, is paid about 40 per cent less than other wage employees of the same sex, age and educational characteristics (ILO, n.d.).⁶⁶ Because the alternative to outsourcing household and personal care services to someone on the market is self-provisioning (i.e. unpaid work), which has no direct financial cost, “any paid service which might replace women’s domestic labour will never be ‘cheap enough’” (Windebank, 2010).

The low social value assigned to care is also reflected in how care is treated by public policy. For example, a low level of public support for care services or lack of public care provision and shortage of care workers may reflect the inferior treatment of care in comparison to other national concerns, such as industrial growth or national security. This may also reflect a notion of “citizenship” that is based on typically male activities (Knijn and Kremer, 1997, cited by Daly, 2001, p. 36). For example, initial versions of social protection programmes are, in large measure, built around labour market participation, particularly men’s full-time participation, based implicitly on women’s unpaid care work. Only since the late twentieth century, with the emergence of modern welfare states and the waning of the male breadwinner model, has public care provisioning and support, in varying forms and degrees, begun to assume major importance (Lewis, 2001, p. 58).⁶⁷ Since the mid-2000s, some welfare states have adopted various policy measures (e.g. parental leave) designed to bring more women into the labour market. For example, EU members have been encouraged to provide more alternative childcare provision, not so much because the priority of care needs per se had risen in the public policy agenda, but more because it was regarded as instrumental to bringing more women, an “untapped labour reserve”, into the labour market, thereby promoting employment and social inclusion as well as gender equality in employment, possibly reversing declining fertility rates, while enhancing child development (Plantenga and Remery, 2009; Daly, 2011; Commission of the European Communities, 2008).⁶⁸

3.3.3. UNEQUAL RELATIONS OF CARE: GENDER, RACE AND CLASS

Because care is indispensable to human well-being and the development of people’s capabilities, *whose* and *which* care needs are addressed and met have implications for equality. A stark example is maternal health, which mirrors inequalities in women’s access to quality care before, during and after childbirth, between the rich and the poor. The maternal mortality ratio is much higher in developing countries (239 per 100,000 births) than in developed countries (12 per 100,000) (WHO, 2017).⁶⁹ Another simple example is how deficiencies in basic education disadvantage girls and boys in accessing future learning opportunities, which are critical in enabling them to realize

⁶⁶ This finding is the result of log regression analysis of hourly earnings using the Philippines Labour Force Survey microdata set from 2010.

⁶⁷ Modern welfare states include France, Germany and the Netherlands, as well as the Nordic countries, such as Denmark, Finland, Iceland, Norway and Sweden, which employ a system known as the Nordic model.

⁶⁸ In 2002, at the Barcelona summit, EU Member States adopted the following targets: Member States should remove disincentives to female labour force participation and strive, taking into account the demand for childcare services and in line with the national patterns of childcare provision, to provide childcare by 2010 to at least 90 per cent of children between 3 years old and the mandatory school age and at least 33 per cent of children under 3 years of age.

⁶⁹ Less than 1 per cent of maternal deaths occur in high-income countries. Globally, approximately 830 women die every day due to complications related to pregnancy and childbirth; roughly 550 of these women live in sub-Saharan Africa and 180 live in Southern Asia, compared to eight in high-income countries. Most maternal deaths can be prevented by the provision of skilled care during childbirth and access to emergency obstetric care. In sub-Saharan Africa, less than 50 per cent of women are attended by a trained midwife, nurse or doctor during childbirth. Women and girls living in fragile states or those in humanitarian crises face some of the highest risks (WHO, 2017).

fulfilling adulthoods and secure productive employment (Guarcello et al., 2014; Brown, 2012).⁷⁰ While poverty forces many households to withdraw children from school and send them to work, many children are working at least in part because education is unaffordable, inaccessible or seen by their parents as irrelevant (Brown, 2012).

Moreover, because giving care entails costs (unpaid care entails physical effort, emotional input, time, lost opportunities, forgone earnings and risks), *how* care is given and *by whom* also have substantive significance for equality. Inequalities may result from the allocation of care provision and care responsibility. A most basic example is the unequal distribution of care responsibilities between men and women, which translates into heavier losses in terms of economic opportunities and earnings for women. A cross-country study by Ferrant et al. (2014) established the link between hours devoted by women to unpaid childcare and low female labour force participation rates, and between inequality in the distribution of care responsibilities between women and men and gender gaps in labour force participation.⁷¹ For women who have no social or economic resources to outsource their care tasks to someone else, the care burden puts them at great disadvantage in comparison to other women and men in the paid labour market, which leads to further disadvantages, such as in social security benefits and economic decision-making in the household. A study of Chile's afterschool childcare by Martínez and Perticará (2017) established that free afterschool care for children aged between 6 and 13 years old had a positive impact on women's labour market outcomes: increasing employment by 5 per cent and labour force participation by 7 per cent.

At the same time, social relations of care are intertwined with existing structures of power and inequalities of gender, race and class (Razavi, 2007, pp. 1–2). For example, historically and across developed and developing countries, women from poorer and disadvantaged racial and ethnic communities have tended to provide the labour (for little or no pay) to meet the care needs (household maintenance, personal care) of more powerful social groups while their own needs have been neglected (Razavi, 2007, p. 2). Because of the low social status of domestic work, individuals who perform paid domestic work tend to come from poor areas and population groups who are already facing discrimination and inequality on grounds of sex, ethnicity, race and nationality, which in turn further reinforces the social stigma of domestic work.⁷² Their labour is cheap, an acceptable substitute for work that the family could provide themselves without pay.

Migrant care workers carry social identities relating to their gender, race and class. Their role and position in destination countries would be better understood in the context of the embedded social

⁷⁰ Guarcello et al. (2014) reports on the findings of an Out-of-School Children study of 25 developing countries which analysed national secondary data from varying years ranging from 2001 to 2011. The study showed that child labourers are more likely to be out of school, either because they dropped out of school or because they never enrolled in school. Viewed from another angle, out-of-school children are more likely to be child labourers than children attending school. In addition, the likelihood of school non-attendance increases with the number of hours spent in employment.

⁷¹ There is empirical evidence that the presence of young children negatively affects women's earnings. See Aguëro et al. (2011); they analysed cross-sectional data from the third round of the Demographic and Health Surveys (DHS III) collected between 1994 and 1999. See also Orbeta (2005) on the Philippines, using household survey data.

⁷² In India, certain tasks are considered "dirty", "manual" and thus carry social stigma, and women from better-off families or of higher castes would not personally perform these tasks, but would rather employ female domestic workers from lower castes to perform them at very low pay (ILO, 2016a, p. 25). Minimum wage rates are set by task, and reflect the lowest social status assigned to tasks deemed unclean and performed by scheduled tribes and scheduled castes (Neetha, 2015). In Latin America, indigenous peoples and people of Afro-descent are overrepresented among domestic workers. In Chile, 28 per cent of domestic workers are Mapuche women. In Bolivia, a large proportion of domestic workers are women from the Quechua, Aymara or other indigenous communities while, in Guatemala, 70 per cent are indigenous. In Chiapas, Mexico, domestic workers come from indigenous communities of Guatemala and El Salvador (ILO, 2016a, p. 26, citing various sources). The Afro-descendent populations in Latin America, due to inequalities in education and discrimination, also suffer from labour market segregation and are over-represented in domestic work: in the metropolitan region of Rio de Janeiro, about 40 per cent of black or mixed race women work as domestic workers while only 15 per cent of white women do (ILO, 2016a, p. 26).

structures of gender, race and class in care economies. In the current international division of care labour, massive numbers of migrants (the overwhelmingly majority of whom are women) generally move from developing, relatively poorer countries to developed, richer countries (refer to section 1). With regard to domestic work in Europe, for example, Gallotti and Mertens (2013, pp. 13–14) concluded from country studies of Belgium, France, Italy and Spain that gender and nationality/ethnic segmentation relate to both the migrant workers' likeliness to participate in domestic work, the type of employment arrangement and the tasks performed in it. In the United States, employers of domestic workers surveyed by the Domestic Workers Union and Data Center (2006) were white and born in the United States while the overwhelming majority of domestic workers were immigrant women of colour. In MERCOSUR countries, while domestic workers used to come from rural areas to work for better-off households in cities, the domestic sector is currently characterized by high concentrations of immigrants from one country of origin, such as Peruvians in Chile, Nicaraguans in Costa Rica, Paraguayans in Brazil and Haitians in the Dominican Republic (Tokman, 2010).

3.3.4. TWO KEY PARTIES, TWO PERSPECTIVES OF CARE

Care policies and programmes should aim for the provision of “good quality care”. But what constitutes good quality care? Daly (2001, pp. 47–48) posits that the viewpoints of both the care recipient and the caregiver are important. Taking the perspective of the care recipient seems self-evident, and has dominated the discourse and policy agenda on care provision. From this viewpoint, “quality of care” may refer to whether the service is up to established standards or below standard, whether the care service or the care worker is flexible enough to adjust to the specific needs, preferences and circumstances of the care recipient, the adequacy of the care payment or allowance received to purchase appropriate care, the choices available regarding carers, location of care and care facilities, and the nature of the relationship within which care is received.

The needs and circumstances of care workers, i.e. the individuals (employees of the private household or an enterprise, or self-employed) directly providing the service to the care recipient, are hardly considered. Yet, they are an integral part of the social process of care. In the same way that care recipients have concerns about standards, having choice and security in receiving care, care workers have their concerns too – the opportunities for giving care, the choice about how to give care, the relationships in which care is given, the contractual arrangements and working conditions under which they give care and, not least, their own needs and interests as individuals and members of a family.

3.4. MIGRANT CARE LABOUR: INTERPLAY OF CARE REGIME WITH MIGRATION AND EMPLOYMENT REGIMES

Migrant care workers are not present on the same scale and in the same way in each type of care service in each country. The conditions in which they work and provide care vary between these types and national contexts. The role of migrant women and men in care economies can be understood as the result of the “dovetailing” of care regimes with migration and employment regimes of destination countries (Williams and Gavanoas, 2008; Williams, 2012).

A “regime” is not only a set of policies and laws, but also encompasses the fabric of cultural norms and social relations that define people's expectations, preferences and behaviour, which will have sub-national differences of gender, class, ethnicity, race and location. Williams (2012, p. 371) defines “regimes” as denoting “clusters of policies, practices, legacies, discourses, social relations and

forms of contestation that are relevant to the particular care/migration/employment regime”. Box 3.1 presents indicators suggested by Williams (n.d.) that may characterize and differentiate these three regimes. In a sense, the concept of “regime” captures the interlinkage between the macro level – policy, laws, regulations and cultural codes; the meso level – formal and informal organizations agencies, and networks; and the micro level – practices and situations of individual actors, defined by gender, class, race, ethnicity, etc. (Lutz and Palenga-Möllenberg, 2011; Williams, 2012).

Care, employment and migration regimes are permeated by a gender script – the cultural script which codes roles, tasks and responsibilities as either feminine or masculine, and defines the relative position of girls and boys, women and men with respect to resources and decision-making.

3.4.1. CARE REGIMES

In addition to the distribution of care responsibilities – who pays, who cares, who decides – among the key institutions (“care diamond”, figure 3.1) and the policy and regulatory framework that governs these care responsibilities, a care regime has an underlying “care culture” (and sub-cultures) that define what type of care is most appropriate and desirable, including who should provide care. The care regime is intimately intertwined with gender relations: how unpaid and paid care work is equally or unequally distributed between women and men; how care work and paid work are (un)equally assessed and valued financially and socially; which gender roles receive institutional support from the state (Lutz and Palenga-Möllenberg, 2011).

For example, European care regimes have been characterized on a sliding scale, from traditional care regimes associated with a conservative gender script at one end, to equality in both regimes at the other. Southern European states (e.g. Italy) are often seen as traditional, with a strong male breadwinner model, reliant on the family, women especially, for childcare and older person care within the home setting, while Nordic states (e.g. Sweden), are regarded as the most equal, providing generous parental leaves and publicly subsidized childcare to enable women to work (Williams, 2012). Typologies, however, are not clean-cut. There are many variations in care provisioning, not least with respect to the relative roles of the family, state and private sector, and the gender relations and women’s care role underlying these care arrangements (more discussion in subsection 3.2.2 and section 4).

To illustrate differences in “care regimes” and the way care responsibilities may be distributed across paid/unpaid, public/private, home/institutional and informal/formal domains, one can look at the various approaches to supporting and funding childcare (Adamson and Brennan, 2016 p. 4). Childcare regimes may be differentiated by (i) the extent of availability and nature of public and market childcare services, especially for children under school age; (ii) policies that facilitate parents’ involvement in both direct care and paid employment, such as paid maternity, paternity and parental leaves; and (iii) cash allowances or subsidies that help families to purchase childcare or employ a care worker. The underlying “care culture” might consider one of the following more socially appropriate and desirable than the other: engaging surrogate mothers (family members, mostly mothers, providing full-time childcare); mothers working and providing childcare part time; intergenerational help; shared parental care; or professional day care (Williams and Gavanas, 2008). Regarding the availability of care services and support, it is not only the absence of such support for specific groups that matters, but also the nature of the support provided. For example, a shift from providing state-funded day care for pre-school children to giving families cash allowances to buy childcare services, has, in certain countries, encouraged families to employ cheap migrant care labour, as discussed in section 4.

The care regime creates opportunities and demand for migrants to provide care labour in a particular country and, in conjunction with current migration and employment laws, has implications for the

employment situation and working conditions of paid care workers. For example, employees of private households in many countries are not covered by legal caps on working hours and have no rights to a minimum wage, overtime compensation and social security (ILO, 2013). Even when regulations govern the employment conditions of household employees, households may be beyond the effective coverage of labour inspection and enforcement mechanisms (ILO, 2015b). Institutional care providers might imply a formal employment relationship and compliance with minimum labour standards, although undeclared, informal employment is also known to occur in formal establishments.

3.4.2. MIGRATION REGIMES

Migration regimes are characterized by their immigration policies – rules governing entrance into a country, quotas and special arrangements for particular groups of people, settlement and naturalization rights, as well as employment, social, political and civil rights accorded to migrants. Just as important to the situation of migrants are the internal norms and practices which govern relationships between majority and minority groups, and the extent to which these are framed by laws against discrimination and strategies for cultural pluralism, integration or assimilation (Williams and Gavanas, 2008, p. 16). Migration policies can embed gender, race and class inequalities. For example, the West German “guest worker” system of 1955–1973, which recruited male workers from abroad, was undertaken not because there was a general shortage of labour (i.e. of men and women) but because of a preference for a “housewife marriage” model in the State policy which precluded encouraging women to enter the workplace (Lutz and Palenga-Möllnbeck, 2011, p. 352).

As discussed in subsections 2.3.2 and 2.3.3 above, biases in immigration policies of OECD countries tend to prioritize professions linked to production sectors, which tend to hire men, rather than “welfare-related” professions, such as health, education and public services, which hire more women. Moreover, many countries give priority to “skilled work” while considering care work to be less skilled work. Restrictive controls on the entry of migrants to take up care jobs, even where there is high care demand but few takers among native-born workers, create an environment that channels migrants, most often women, into care jobs under unfavourable or precarious conditions (further discussion is presented in section 4), and can push some migrants into taking unsafe migration routes (Lutz and Palenga-Möllnbeck, 2011; GAATW, 2013). On the other hand, some European states, such as Italy (already cited previously), have adopted immigration policies that are favourable to the entry of migrant domestic workers to enable women nationals to reconcile care responsibilities and paid work.

By defining the legality or illegality of migrant status, and assigning or withholding certain economic, social and civic rights, immigration policies shape the employment situation of migrant care workers. Immigration controls also structure their relations with their employers and other care workers, which could be highly unequal (Shutes and Chiatti, 2012, p. 399). At the same time, conditions attached to a legal/regular status may restrict employment to particular sectors of the labour market and to particular occupations, or tie the worker to a specific employer for which a work visa was obtained. Holders of student and holiday worker visas may have the right to work only for a fixed time period with limited benefits. Entry into and exit from care work are therefore not purely matters of “choice” for migrant workers. An irregular (“illegal”) status may leave few options open to migrant workers apart from entering “irregular” types of jobs, which are precarious, offer low wages and poor working conditions, and often put a worker in a weak bargaining position in relation to their employer. A migrant status that has no right to permanent residence and where residence rights are tied to a particular employer often means vulnerability to poor terms and conditions of employment. As section 4 shows, migrant workers without rights of residence and/or employment within a country are

considered to be the main source of care labour in private households and in less regulated segments of the care labour markets (Shutes and Chiatti, 2012; Simonazzi, 2009). They are over-represented in privatized care services and are the backbone of live-in care arrangements in many countries (Da Roit and Weicht, 2013, cited by Da Roit and van Bochove, 2017, p. 77).

Policies and attitudes towards immigrants and foreign-born workers shift over time, from openness to restriction, and back; between exclusionary and assimilationist; between countering race discrimination and greater restrictions on asylum seekers; between needing migrant workers to provide long-term care for older citizens and not wanting them to remain permanently.

3.4.3. EMPLOYMENT REGIMES

In addition to the conditions attached to a care worker's migrant status, the country of destination's employment regime shapes the employment situation and working conditions of migrant care workers. As with the care and migration regimes, the employment regime consists of the labour policy and regulatory framework, and socio-cultural norms and values concerning employment relationships, worker and employer rights and obligations, compliance with labour regulations, etc. at the macro level; institutions and organizations at the meso level; and formal and informal employment arrangements, relations and practices at the micro level.

The policy and labour regulatory framework clarifies the rights, entitlements and obligations of parties to the employment relationship, sets labour standards, such as minimum pay, cap on working hours, overtime compensation, payments in kind for board and lodging, and protects workers' access to redress mechanisms and freedom to organize and join workers' organizations. Depending on their design, scope and manner of implementation in a given country context, these regulations may de facto, totally or partially, exclude certain groups of care workers and migrant workers from recognition and protection of their labour rights and from social protection. For example, private households as employers are very often treated differently from enterprises and government agencies – either they are not expected to fulfil the same obligations towards their employees as establishments or they are simply seen as being outside state surveillance. Applicable labour regulations for private enterprises may be different from those that govern public enterprises and agencies, and these may also vary according to the size of the employer (e.g. microenterprises with fewer than five employees or own-account businesses might be exempted from certain labour standards), economic activity and location (rural areas versus cities; state-specific rules in a federal government system).

Domestic workers – those who work for or in private households in an employment relationship – represent one category of workers who are excluded from coverage of labour protection laws in many countries.⁷³ In 2010, almost one-third of domestic workers across the world were completely excluded from the scope of national labour legislation, and only 10 per cent were covered by labour regulations specific to domestic workers (ILO, 2013). Where domestic workers are covered by labour law, their entitlements are typically less favourable than those of other care workers. Labour regulations are stratified among care workers too. In Argentina, pre-school teachers are in comparatively well-regularized and well-organized employment situations, while the basic rights of many domestic workers are not protected (Esquivel, 2017). There are situations where national labour regulations cover domestic workers generally, but exclude particular sub-groups of domestic workers. For example, in the United States, under the 2013 Department of Labor regulations, live-in homecare workers who

⁷³ See also *ILO General Survey on the fundamental Conventions*, 2012, for the implications of exclusion from the scope of labour legislation on the enjoyment of the fundamental rights of freedom of association, forced labour and child labour and non-discrimination and equality of treatment.

are privately paid by employing households are excluded from federal overtime protection (Goldberg, 2015).⁷⁴ Migrant workers who enter home-based care work (or domestic work) in countries where laws do not protect domestic workers at all, or not to the same extent as other workers, will be more vulnerable to labour exploitation (long working hours, low pay, etc.) than other categories of workers.

The wage penalty suffered by care workers is the result of low social status and discriminatory treatment of care workers (as discussed in subsection 3.3.2), but it is also influenced by labour regulations (e.g. whether care workers are covered by the same minimum wage protection that is applicable to other workers; effective enforcement of the law). The research by Budig and Misra (2010) points to variations in the incidence and severity of care penalties across advanced industrialized countries. The research found that, as a general rule, wage penalties tended to be higher in countries with greater income inequality, less centralized collective bargaining and a smaller public sector. Where overall income inequality was low and the public sector was large, those in care occupations even enjoyed wage premiums in comparison to non-care workers with similar characteristics.

Weakly regulated labour markets might be more likely to breed reliance on low-wage labour in private care services, as some comparative work on advanced industrialized countries seems to indicate (Morgan, 2005). The absence of labour contracts in poorly paid care jobs is easy to conceal. Wages and working conditions of care workers are influenced by the specific labour market environment. Tolerance for undeclared work and informal employment arrangements, predominance of traditional arrangements based on kinship and reciprocity and weak law enforcement mechanisms are among the factors that sustain irregular and informal employment arrangements.

Box 3.1. Care, migration and employment regimes: Indicators for cross-national comparison

Salient factors in the relationship between migration and care work and the aspects that characterize and differentiate each regime are detailed below.

Care regimes

- policies facilitating carers' involvement in paid employment, e.g. maternity/paternity, parental/carers' leaves
- the extent and nature of provision for children under school age and older and disabled people (public/ voluntary/ market; formal/informal care)
- the nature of direct support and its conditionality (e.g. direct payments, care allowances, cash benefits, tax credits)
- the extent and characteristics of the care workforce (e.g. gender, conditions, gaps, skills, public/private)
- "care cultures" (i.e. dominant national and local cultural discourses on gender and care, on what constitutes appropriate care, such as familial or institutional care for older people)
- historical legacies of care policies and domestic work practices
- the significance of movements, organizations and mobilizations concerning care (e.g. public sector unions)

⁷⁴ The FLSA is the federal law that establishes minimum wage, overtime pay, recordkeeping, and child labor standards affecting full-time and part-time workers in the private sector and in Federal, state, and local governments. In 1974, Congress extended FLSA coverage to workers who perform "domestic service" but the law also exempts certain domestic service workers from the FLSA's minimum wage and overtime provisions. In 2013, the Department of Labor amended its regulations, extending federal minimum wage and overtime protections to all direct care workers employed by home care agencies and other third parties, but exempted from these protections "casual babysitters" and "domestic service workers" employed by an "individual, family, or household solely or jointly employing the worker" to provide "companionship services" for an elderly person or a person with an illness, injury, or disability" (U.S. Department of Labor, 2013a, 2013b).

Migration regimes

- immigration policies – rules for entrance into (and exit from) a country (quotas, special arrangements, as primary applicants/dependants)
- settlement and naturalization rights
- employment, social, political, legal and civil rights, both formal and in the “lived experience” (e.g. where migrants are denied rights and fall into illegality)
- internal norms and practices which govern relationships between majority and minority groups (e.g. laws against discrimination, strategies for advancing multiculturalism, integration, assimilation and their implementation in care work sites)
- histories and gendering of migration and emigration to particular countries (e.g. colonialism, old trade routes and shared political, economic or religious alliances)
- the significance of movements, organizations and mobilizations concerning migration and race relations

Employment regimes

- labour market divisions, exclusions and hierarchies (skills, gender, ethnicity, nationality, migrant status, disability, age, place of work, working hours, forms of indentured labour)
- processes of deregulation, deskilling, precarious and flexible labour
- forms of social protection (eligibility to unemployment and sickness benefits, pensions, minimum wage, rights attached to care responsibilities)
- production-related discourses (male breadwinner or dual worker, welfare-to-work schemes, labour market activation)
- forms of mobilization, contestation and solidarity across different groups (e.g. trade unions, migrant workers' rights organizations)

Source: Williams, n.d.

4

EMPLOYMENT AND WORKING CONDITIONS OF MIGRANT CARE WORKERS

Section 4 is concerned with the employment patterns and working conditions of migrant care workers in destination countries. Why do migrant workers play a significant role in the care economies of some countries but not others, more often in certain contexts than in others? What is driving the demand for migrant care workers, and under what conditions are they being made to work? Are these conditions less favourable than those of other, non-migrant workers? This section addresses these questions.

The starting point of this analysis is the demand for care services, which is defined by the care regime – how the provision of the care is organized and delivered, who pays for the care and the social norms underlying care.

The next point of analysis is the “dovetailing” of care demand with immigration policies and controls, which determine who can legally enter a country and under what conditions they can stay and work (or not work). Migration policies open channels through which migrants can enter and work as care workers in the host country. These different gateways produce different migrant statuses, each associated with different rights, freedoms and restrictions in respect of residing in the host country and participating in its labour markets (refer to section 3). One’s migrant status defines one’s social location in the host country, including one’s rights in the labour markets and, in turn, one’s employment pathway (Fudge, 2012).

The employment patterns and working conditions of migrant care workers greatly depend on their migrant status. But these are also determined by the extent to which a particular segment of the care economy is governed by labour regulations. A stark example is domestic work (e.g. Argentina discussed by Esquivel, 2017; United States direct care workers discussed by Goldberg, 2015). Other examples are presented below, including differences in employment patterns and working conditions of older person care workers employed by state-run residential and nursing homes, by private agencies or directly by private households.

Section 4 is divided into two subsections. Subsection 4.1 illustrates, through the presentation and comparison of eight country cases and one subregion (the GCC group of countries), how care, migration and employment regimes interconnect and together shape the role and position of migrant labour in providing care – detailing the applicable segment of the care economy, determining whether the role is major or minimal and examining employment patterns. As explained in section 1, the care regimes discussed in this report are limited to the provision of older person care, childcare and/or family and household care (relational, person-care and non-relational care of the household). The

selected countries and subregion apply different care and migration regimes, from which emerging patterns can be discerned. The case studies are based purely on secondary research and data sources.

Subsection 4.2 focuses on the main issues pertaining to the employment and working conditions of workers engaged in the provision of older person care, childcare and family and household care, whether in institutions (establishments) or in the home of care recipients.

The following discussion of country care systems will involve many terms that have been used by the countries to refer to various types of care service and care workers. These can be quite confusing. To help the reader and to minimize repetitive definitions within the discussion, box 4.1 provides a glossary of the terms used.

Box 4.1. Terms often used in relation to care work and care workers

Care work

Defined broadly as consisting of activities and relations involved in meeting the physical, psychological and emotional needs of adults and children, old and young, frail and able-bodied.

Care workers

Persons who perform care work, paid or unpaid, in institutions or at home, under formal or informal arrangements.

Childcare, child care

The caring for and supervision of a child or children, usually from the age of 6 weeks to 13 years of age.

Childcare worker

One who provides childcare at home or in an institution. May be paid or unpaid.

Direct care workers

Care workers who deliver hands-on, face-to-face services to care recipients. Typified by workers who deliver care in the home of care recipients, day care centres, nursing homes and other residential care homes.

Domestic work

Work in and for private households. Covers a wide range of possible tasks, including taking care of young children, frail older persons, persons with disabilities or chronic illness and the overall basic needs of a family: cooking, buying food, laundry, gardening, cleaning and driving a car for the family.

Domestic worker

A worker who performs domestic work in an employment relationship. May be employed under live-in or live-out arrangements; work full time or part time; be hired directly by the private household, by an employment or domestic work agency or under a triangular arrangement with both private household and agency.

Home care (or domiciliary care)

Covers nursing care and services to assist adults in daily living activities that are delivered at home, where the care recipient resides. Aimed at enabling care recipients, who are partially or totally incapacitated, to remain in their own homes. May include services such as personal care, meal preparation, housework, home maintenance, assistance with administrative paperwork and shopping for daily needs.

Home care agency

An organization that provides home care services.

Home health agency

An organization that provides home health-care services.

Home health care

Health-care services and supplies that a doctor determines a care recipient may receive in his/her home under a plan of care established by his/her doctor.

Institutional care

Care delivered in institutions, such as nursing homes, day care homes, hospices or chronic care units in hospitals. Aimed at persons who can no longer live at home.

Long-term care

Refers to care of adults (often older persons or adults with disabilities or with chronic disease) who are at significant risk of having progressive and/or chronic conditions, who are unable to perform basic activities of daily living, such as dressing or bathing, and who require services to meet their long-term functional needs. Includes both medical and non-medical care. Care services can be provided at home, in the community or in institutions (e.g. hospitals, nursing homes).

Non-person-care

Does not entail face-to-face person-care. Sometimes referred to as “non-relational care”. Typically includes cleaning, cooking, laundry and other household maintenance tasks.

Older Person care (in the source texts variously termed eldercare, elderly care or aged care)

Broad term referring to the fulfilment of the special needs and requirements that are unique to senior citizens, usually classified as those over the age of 65 years old. Encompasses such services as assisted living, adult day care, long-term care, nursing homes or residential care homes, hospice care and home care. Because of the wide variety of older person care situations found nationally, as well as differing cultural perspectives on older citizens, the concept of older person care cannot be captured by one standard practice.

Older person care worker, older person caregiver

One who provides older person care services at home or in an institution. May be paid or unpaid.

Person-care

Direct, face-to-face care of persons; typically includes the work of nannies, childminders, nurses, doctors, teachers, workers in child day care, caregivers in residential care homes and day care centres for older persons, caregivers in private households. Sometimes referred to as “relational” care.

Paid care work

Care work performed in exchange for payment or remuneration in cash or in kind. It may be performed within a range of institutional settings, such as private households (as in the case of domestic workers), public or private hospitals, clinics, nursing homes, schools and other care establishments.

Paid care worker

May be in wage employment, i.e. in an employment relationship where the employer may be a private individual or household, public agency, a private for-profit enterprise or a private non-profit organization. May be working on their own account or self-employed.

Residential care services

Typified by nursing homes and old-age homes.

Semi-residential services

Typified by day care centres and respite care facilities.

Social care

Often used as an administrative term (especially in the United Kingdom), which covers both home and institutional care. The tasks cover physical care as well as “enabling” older people to be independent and as active as possible. Increasingly, social care is delivered in people’s own homes.

Unpaid care work

Care of persons for no explicit monetary reward. Usually undertaken by family members, relatives and friends.

4.1. INTERSECTIONS OF CARE, MIGRATION AND EMPLOYMENT REGIMES

The country cases that follow are presented in clusters according to their predominant care regime, the starting point of this report’s analysis. Based on the literature, typologizing care regimes is not easy for three main reasons: (i) several approaches are possible, depending on the criteria used; (ii) pure types do not exist; and (iii) care policies and institutional structures, and socio-economic norms and behaviours have evolved over the years so that a regime today is not exactly the same as it was in the 1990s. Therefore, before presenting the country cases, a brief explanation of the reasoning behind how the country cases have been clustered is in order.

Various methods of classifying care regimes have been used. Esping-Andersen (1990) proposed a model of three welfare state regimes based on the relation of the state and economy and the

extent to which welfare policies relieve individuals of the necessity to sell one's labour, namely (i) liberal welfare state, in which the market is encouraged by the state, social reform is severely circumscribed by liberal worth-ethic norms, and means-tested assistance and modest universal transfers predominate; (ii) conservative, corporatist welfare state, which is committed to traditional family-hood and motherhood, and to state interference only when the family's capacity has been exhausted; and (iii) social democratic welfare state, which adheres to the principles of universalism of social rights and equality, crowds out the market and socializes the costs of family-hood. This typology has been criticized for, among other things, not accounting for unpaid labour and care provision by the family, and being gender blind (Lutz and Palenga-Möllnbeck, 2011; Razavi, 2007; Lewis, 1997).

Another approach, introduced by Jane Lewis in 1992, focuses on the interrelationship between paid work, unpaid work and welfare, and differentiates states in terms of the strength or weakness of the male breadwinner logic in social security and tax systems, social care provisioning and women's position in the labour market (Lewis, 1997).⁷⁵ States may be "strong", "modified" or "weak" (i.e. weak regimes adhere to a dual breadwinner norm). To characterize care regimes in terms of their underlying gender arrangements, Lutz and Palenga-Möllnbeck (2011, p. 351) outline key questions: whether care work is equally or unequally allocated between women and men; whether care work and paid work are assessed equally in financial and cultural terms; the relationship between care work and paid work; and the institutional support provided by the state. Care regimes are therefore on a sliding scale: at one end, egalitarian in respect of gender and care (the Nordic states are always cited as examples); and at the other end, conservative and traditional.

Finally, Williams (2012) suggests differentiating care regimes based on the relative roles of the state in the formal provision of care services and support and of the family in the informal provision of care (Williams, 2012). Two ideal types have been identified: at one end, the Southern European "familialist care model", with high levels of unpaid care provided by the family (particularly women) and minimal public provision of care services; and, at the other end, the "public services model" of Nordic countries, with an egalitarian care and gender regime and high levels of provision of public care services (Williams and Gavanoas, 2008).⁷⁶ This approach comes close to the "care diamond" schema presented in section 3, which includes the other institutional sites of care provisioning, i.e. the market and the non-profit/voluntary sector, which take on the balance of care work, to a greater or lesser degree, from the family and/or state. The care diamond schema implies that the roles of the family, the state, the market and the non-profit sector vary only in degrees relative to each other. This is important to bear in mind as the past decade has witnessed the market playing an increasingly important role, and the emergence of mixed private-public delivery models and "quasi-markets" in which the state provides the finance but the private for-profit and the voluntary sectors deliver the service.

Mindful of the aforementioned issues, country cases below are grouped in terms of the relative primacy of the family, the state or the market/private sector in care provision and funding; the strength or weakness of the male breadwinner norm, as indicated by their female labour force participation rates (see figures 4.1 and 4.2); and their migration regime. Table 4.1 presents the classification of the country cases.

⁷⁵ The model is not unproblematic. Lewis (1997) discusses both her model and critiques of it further, as well as the complications involved in coming up with gender-centred measures of care regimes.

⁷⁶ Williams and Gavanoas attributed these two ideal types to Anttonen and Sipilä (1996).

Table 4.1: Combination of care and migration regimes: Country examples

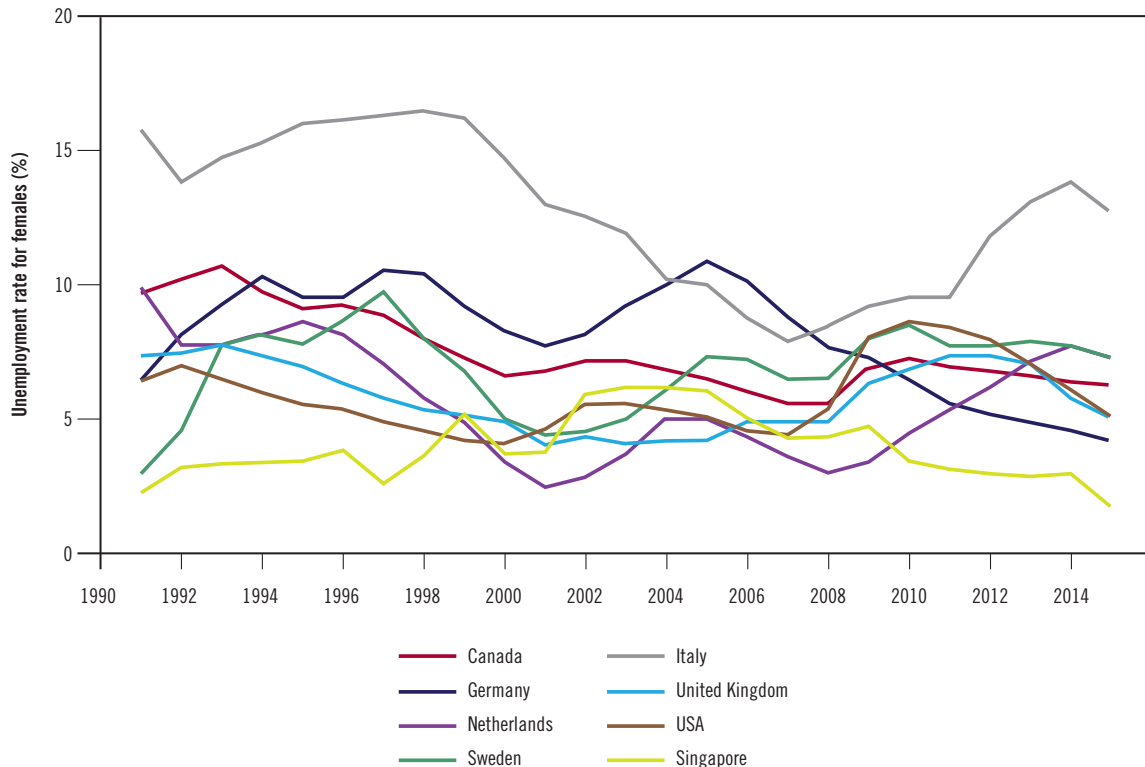
		Care regime: Principal care institution			
		Family	State	Market-Private	Mixed
		Familialist. Primary reliance on family for care. Minimal-low level of publicly funded care services.	Public services. High level of publicly funded care services. State offers generous childcare and eldercare benefits.	Private sector dominates care services. State offers means-tested assistance.	Statutory social insurance and strong state coordination.
Male breadwinner norm	Migration regime				
Strong	Highly regulated. Reliance on care-specific foreign worker scheme.	GCC countries			
	Lightly managed migration, less restrictive	Italy			
	Closely managed immigration. Liberal towards skilled, restrictive towards less-skilled.				Germany
Modified	Highly regulated. Reliance on care-specific foreign worker scheme.				
	Lightly managed migration, less restrictive				
	Closely managed immigration. Liberal towards skilled, restrictive towards less-skilled.			United Kingdom	
Weak	Highly regulated. Reliance on care-specific foreign worker scheme.	Singapore			
	Lightly managed migration, less restrictive				
	Closely managed immigration. Liberal towards skilled, restrictive towards less-skilled.		Sweden Canada	United States	Netherlands

Italy, Singapore and the GCC countries conform most closely to the “familialist care model”. The state plays a minimal role in providing and financing care services, apart from some measures to assist families in coping with the demands of childcare or older person care (e.g. cash-for-care allowances, facilitated recruitment of foreign care workers; a few in-kind care services). But, while Singapore has posted relatively high female labour force participation rates (52.6 per cent in 2000, 58 per cent in 2016), women in Italy and the GCC countries have posted very low rates, at less than 50 per cent. These countries differ slightly in their approach towards migrant care workers. Both GCC countries and Singapore have implemented substantial care-specific temporary worker programmes. Italy has opened special migration channels to allow foreign domestic workers to stay and work in Italy.

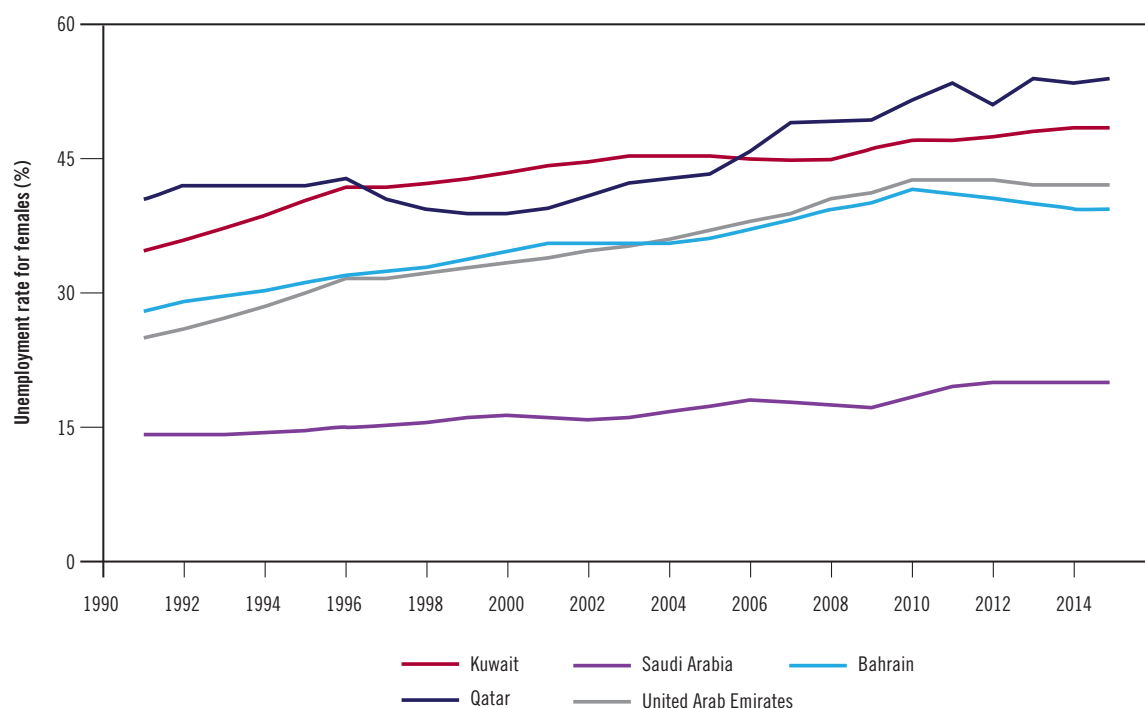
Sweden and Canada conform to the “public services model”. Public provision of childcare and older person care services and support in Sweden has been in existence for a long time, and is relatively generous. In Canada, although it has no single national universal approach to older person care and childcare, the bulk of the costs is covered by provincial, territorial and federal taxes. Women’s participation rates in both countries are quite high: in 1990, 62 per cent in Sweden and 58 per cent in Canada; and in 2016, 61 per cent in both countries. Permanent and temporary immigration to Canada is much more substantial than to Sweden.

In contrast, in the United Kingdom and the United States, the private market plays the dominant role in the provision of care services, the financial burden of childcare and older person care falls most heavily on the family or care recipient, and state assistance is means-tested and targeted to low-income populations. Women’s labour market participation rates, while lower than those of Sweden or Canada, have been at medium-high level, similar to Singapore’s.

Figure 4.1. Female labour force participation rates of selected countries, 1990–2016



Source: TheGlobalEconomy.com, The World Bank. <https://www.theglobaleconomy.com>.

Figure 4.2. Female labour force participation rates in selected GCC countries, 1990–2016

Source: TheGlobalEconomy.com.

Two countries are in a “mixed group”. Both Germany and the Netherlands have adopted and implemented a statutory social insurance system, funded from workers’ wages, employers’ contributions and taxes, to meet childcare and older person care needs (but excluding health care, which is dealt with separately). Germany has strong male breadwinner and familialist care norms, while Dutch policies have enabled women and men to combine paid work with family care responsibilities, with the result that women have posted medium-high female labour force participation rates (albeit that many are employed on a part-time basis). These countries have a closely regulated approach to immigration.

4.1.1. FAMILIALIST CARE MODEL

4.1.1.1. Italy’s older person care: Woman-in-the-family to “migrant-in-the-family”

Care regime: Italy’s care regime is based on a care culture that assigns to the family (mainly women) the primary role in ensuring the welfare of financially and physically dependent family members. The state plays a subsidiary role in comparison to the family.⁷⁷ This reliance on the family to organize and provide childcare and older person care has contributed to Italy’s low female employment rates, which

⁷⁷ The Christian Democrats, who dominated politics until the early 1990s, supported the Catholic ideal of the primacy of the family role, and care provision by church-related organizations. The 1948 Italian Constitution delegated responsibility for social assistance and social care to local and regional authorities, which resulted in uneven financial capacity and level of care services across the country. See van Hooren, 2011, p. 44, who cited various sources.

are some of the lowest among European countries.⁷⁸ On the grounds of looking after children and incapacitated adults, close to 30 per cent of women aged 25–49 years old were economically inactive, and more than 20 per cent of women aged 25–64 years old worked part-time in 2015 (European Commission, 2016c).

The level of public services is quite low; much of it is contracted out to private for-profit and non-profit service providers.⁷⁹ Public care support for older person care principally consists of cash transfers, tax breaks and cash-benefits to persons in need and their families. The most common of these cash benefits is the “*indennità di accompagnamento*” (IA), an allowance granted to all older persons in need (i.e. those unable to work and in need of constant care in everyday activities), to purchase care services directly from the market or employ care workers, as they choose. The number of IA beneficiaries has been increasing continuously; in 2007, they comprised 1.15 million older persons or 9.8 per cent of the population aged 65 years old and over (van Hooren, 2011, p. 45). Unregulated and with no controls governing how it is spent by recipients, the cash-for-care allowance has been credited for the increase in live-in migrant care workers, who can provide constant care and at a lower cost than residential care or home-care establishments (Shutes and Chiatti, 2012; Castagnone et al., 2013, Da Roit and van Bochove, 2017).

The migrant in the family: Over the years, the “migrant-in-the-family” care model has developed, complementing the “woman-in-the family” model.⁸⁰ The number of domestic workers providing a wide range of person-care and home care services tripled between 1998 and 2008. And, with the phenomenal expansion of the domestic work sector, the presence of migrants – EU citizens and non-EU nationals – in home-based older person care grew exponentially as well. In 2011, more than 80 per cent of the 881,702 domestic workers were foreign-born; and this was just the tip of the iceberg, as many more were migrants in an irregular situation and thus not registered (Castagnone et al., 2013, p. 7). As Castagnone et al. concluded, “salaried caregivers – called *badanti* – often employed as live-in, are nowadays the backbone of the eldercare system in Italy, in a welfare mix that combines the help provided by relatives with the few opportunities offered by public and private care services at local level” (2013, pp. 7–8).

Migration regime: The general immigration rule imposed by Italian law is nominal hiring from abroad – non-EU workers are allowed entry and employment only upon specific, individual request submitted by a national or a regular resident. Admissions for employment purposes are subject to quantitative caps, determined by the Government, and quotas are distinguished for seasonal and non-seasonal employment.

Since 1998, special quotas have been reserved for domestic workers, which include housekeepers and babysitters (“*collaboratrice familiare*” or “*colf*” for short), and older person care assistants (“*badanti*”). This special quota has grown: around 30 per cent of the non-seasonal employment quota was reserved for domestic workers in 2005, and this reached 70 per cent in 2008. Following

⁷⁸ In 2015, women’s employment in Italy stood at 50.6 per cent, while the lowest rate was posted by Greece, at 46.0 per cent. At full-time equivalent employment rate, the women’s rate falls to 43.7 per cent and the men’s to 68.3 per cent, because women are engaged in part-time employment at a much higher rate than men: at over 30 per cent and under 10 per cent, respectively (European Commission, 2016b).

⁷⁹ Pensions and unemployment benefits are generous for those in the labour market but there is no comprehensive social assistance system that guarantees a minimum welfare level for all citizens. While the state provides a universal health-care system, it plays a very limited role in social care. Voluntary organizations related to the Catholic Church have traditionally provided care services for older persons. With regard to childcare, most children aged 3–6 years old attend pre-schools free of charge. But children aged between 0 and 3 years old rely on family (mothers and grandmothers) or local community assistance, which is based on eligibility criteria and parental contributions set by the community (van Hooren, 2011, p. 46).

⁸⁰ According to van Hooren (2011, p. 54), there is no evidence that migrant workers play a marginal role in agency-based social care and agency-based childcare.

the enlargement of the EU since 2004, domestic workers were likewise targeted through quotas and concessions for workers from the newly admitted countries. Nonetheless, irregular migration has dominated the sector. Irregular entry and overstaying tourist and student visas continued to provide the primary access route to the Italian labour market (Castagnone et al., 2013, p. 13; van Hooren, 2011, p. 52).⁸¹ Among migrant care workers surveyed in Italy, the main reason given for working in care in the household was that this care job was the only, or the easiest, way to enter and work in Italy within the constraints of the country's migration framework; respondents also indicated that such jobs were easy to find (Shutes and Chiatti, 2012).

Although Italy's migration policy has taken on a more restrictive and punitive approach towards irregular migration since 2008, domestic workers have continued to be treated as the exception.⁸² Migrant domestic workers were the main beneficiaries of three regularization campaigns: the 2002 campaign, in which half of all applications concerned housekeepers, babysitters and older person care workers, and 90 per cent concerned women; the 2009 campaign, which exclusively targeted domestic workers despite the economic crisis; and the 2012 campaign, open to all migrant workers but in which 86 per cent of applications concerned domestic workers (Castagnone et al., 2013, p. 14). Regularization depends on the willingness of the employer to apply for regularization of status, which implies higher labour costs arising from compliance with social security contributions, higher wages, hours of work and leave entitlements stipulated under the collective agreements on domestic work. Not all employers are willing or able to bear these additional costs.

Employment regime: Up to 1974, the terms and conditions of domestic workers who performed paid domestic work for the same employer for at least four hours, were covered by Law 339 (adopted in 1958), which set labour standards relating to working time, rest days, paid annual leave, frequency of payment, accommodation for live-in workers and job security. The first collective agreement for domestic workers in 1974 set standards for domestic workers irrespective of their hours of work. Since then, the collective agreement has been renewed seven times, the last being in April 2013, with an expiry date of December 2016. The 2007 agreement was notable because it recognized many more labour rights of domestic workers, including a new professional classification, salary increases and remuneration for holidays and leaves, pension contributions, the same maternity safeguards as other workers, etc. (MIGRANT webpage 2015; Hobden, 2015a). The collective agreement is not universally applicable, and is only compulsory for employers who are members of two organizations of employers of domestic workers, DOMINA or FIDALDO, which have entered into contracts that explicitly or implicitly refer to it. Nevertheless, when workers who are not formally covered by the agreement bring cases to court, judges use the provisions on wages and social security as the standards by which to adjudicate (Hobden, 2015a). At the same time, however, undeclared work, including migrant work in an irregular situation, is generally tolerated. The incidence of irregular employment remains high, although it has declined from an estimated 70 per cent in 2007 to 50 per cent of total employment in the domestic work sector in 2009.⁸³

⁸¹ The share of men in foreign domestic workers peaked at 17 per cent with the 2002 regularization and declined to 12 per cent by 2006. In the same manner, the number of male domestic workers substantially decreased during the two years following the 2009 regularization campaign. Men supposedly left the domestic work sector after having obtained legal status. This finding seems to be corroborated by the fact that almost 70 per cent of applications from domestic workers in the 2012 regularization campaign concerned male domestic workers, mostly from Bangladesh, Pakistan and Morocco. See van Hooren, 2011, p. 52; Castagnone et al., 2013, p. 17.

⁸² Under Law 94 of 2009, effective 2012, all newly arrived third-country nationals applying for a new residence permit are asked to sign an agreement committing themselves to acquire an adequate knowledge of the Italian language and basic norms pertaining to social and civic life in Italy, to respect the Charter of citizenship, educate their children, etc.

⁸³ This result is still much higher than in agriculture (37 per cent), industry (5 per cent) and the service sector (11 per cent) in 2011. Castagnone et al., 2013, p. 31, citing official estimates produced by the national statistics office – ISTAT.

Employment situation of migrant domestic workers: Castagnone et al.'s study of migrant domestic workers in Italy provides an insightful overview of the employment situation of foreign older person care workers in the country (Castagnone et al., 2013). First, work permits are co-terminus with the job contract, but cannot exceed two years; permanent stay may be granted only after five years of regular residence; and stay permits for employment can be renewed only if the person is regularly employed for a minimum of 20 hours per week. Thus, in spite of a high tolerance for irregularity of migrant and employment status, a migrant's status in the country is precarious up until the point when he or she is granted permanent residence. This makes migrant workers more likely to accept sub-standard working conditions in order to maintain their legal status. Loss of a job can cause a migrant to slip back into irregularity.

Second, irregularity of stay and employment in the early stages of migration drives many to accept live-in work, which is the most problematic segment of the labour market for domestic work, where migrant workers are particularly vulnerable to exploitation and isolation. The paper by Shutes and Chiatti (2012, p. 398) gives corroborative data. Wages of migrant care workers differ depending on whether or not they co-reside with the care recipient, and have a regular contract or not. The number of hours worked tends to be very high, reflecting around-the-clock engagement (20 per cent worked 9–12 hours a day and 26 per cent more than 12 hours a day). The job is found highly demanding by interviewed migrants in terms of emotional and psychological tension, physical burden and restrictions on mobility outside the house during the day.

Third, the vulnerability of migrant domestic workers is matched by the vulnerability of their employers. Often, irregular employment of migrant domestic workers is the only viable, affordable option for families in the low to middle strata of Italian society. Most care recipients cannot afford to employ different care workers with different skills for different needs. Older person care assistants ("badanti") multi-task and acquire skills through experience and ad hoc training. But the workload is excessively heavy.

4.1.1.2. Singapore: Foreign domestic workers for older person care

Care regime and entry of foreign workers: Traditional "Asian values" dictate that childcare and care of older parents and relatives are the responsibility of the family. The family is regarded as the "primary caregiving unit" and institutional care as "the last resort". The state policy is to help people "age in place", at home and in the community (Dodgson and Auyong, 2016; Huang et al., 2012). In the 1950s and 1960s, state policy had been geared towards attracting Singaporean women into high-growth industries, such as textiles and electronics, in line with the country's industrialization strategy. Part of the childcare demand was fulfilled by crèches and kindergartens, but these were relatively more costly than live-in domestic workers, who could also relieve women of the burden of unpaid household chores. As long as there was sufficient local supply of domestic workers, the demand for foreign workers remained minimal. However, a growing shortage in local domestic workers and a corresponding increase in their wages resulted in Singaporean wives, mothers and daughters increasingly having to take on unpaid care work, posing a serious challenge to the state's industrialization strategy (Dodgson and Auyong, 2016, p. 4). In 1978, the Singapore Government introduced the Foreign Maid Scheme to facilitate the hiring of domestic workers not only from Malaysia (which already enjoyed privileged immigration arrangements with Singapore), but also from Bangladesh, Burma, India, Indonesia, Sri Lanka, Thailand and the Philippines.⁸⁴ When these

⁸⁴ It was only from 1968 that low-skilled foreign workers (mainly from Malaysia) were brought in to fill gaps in the construction and manufacturing industries. It also became necessary for the Government to facilitate the entry of foreign domestic workers (Dodgson and Auyong, 2016).

measures were introduced, Singapore had around 5,000 foreign domestic workers (FDWs) and a female workforce participation rate of 29.3 per cent. By 1988, these figures had increased to 40,000 FDWs and 45.2 per cent, respectively (Dodgson and Au-Yong, 2016, p. 5).

Older person care regime: As in other developed countries, a rapidly ageing population, declining fertility and rising old-age dependency ratio have increased the demands for older person care services.

A wide range of resources are available to families to cope with their caregiving responsibilities. There are institution-based care alternatives. Chronically ill older people may be placed in community hospitals, chronic sick hospitals and nursing homes run by volunteer welfare organizations and for-profit enterprises.⁸⁵ By 2017, the number of nursing home beds in Singapore had increased from 9,000 in 2011 to more than 12,000, and the Health Ministry was aiming to have 17,000 beds in Singapore by 2020 (Chia Yan Min, 2017). However, these options are expensive and the waiting list for a place is long.

To contain the cost of older person care provision, Singapore has shifted the care responsibility back to the family (primarily women) from institutional care services (re-familialization or de-institutionalization) and has restructured the delivery of health care from skilled health-care professionals to less skilled caregivers (Huang et al., 2012, p. 201). The State's priority is expanding the provision of home-based and day care, through home care, day care and community care centres. The Government has stepped up expansion of home care and day care capacity to ease the demand on hospitals and nursing homes, and to cater for older persons who prefer to stay put in their own homes.⁸⁶ A suite of Government-subsidized services includes weekly house cleaning, daily meal deliveries and transport escort services when needed, targeted at older persons who live alone or have little caregiving support, but they also complement the work of existing caregivers (Au-Yong, 2016). Nursing homes also play a crucial role in the provision of both day care facilities and home care services for older persons. For families able to afford it, the market provides home-visit options by nurses and doctors for the chronically sick. Hospital teams are available for post-hospitalization visits to patients at home or in nursing homes.

Families that can afford it often devolve their responsibility for older person care to foreign live-in domestic workers. A recent national survey found that 55 per cent of those aged 60 and above had a family member as the primary caregiver (Chan, 2010, cited by Huang et al., 2012, p. 201). Family members who provide primary older person care can rely on government agencies, charities and volunteer welfare organizations for home-help services, financial support schemes, meal deliveries and caregiver-training programmes for foreign domestic helpers.

Policy reliance on migrant care workers: Policy adjustments suggest that the State recognizes the increasingly important role that foreign domestic workers play in relieving family members of some of the strain of older person care in the home setting. In the 1990s, Singapore continued to improve its regulations on sponsoring and hiring of foreign domestic workers, and complemented these with various forms of financial assistance: tax deductions since 1991; concessionary rates in 2004 for families with members under the age of 12 and older than 65; additional grants for low- and middle-income families to care for older relatives (Dodgson and Auyong, 2016, pp. 5–6).

These policy reforms resulted in a sharp rise in the number of foreign domestic care workers – a 144 per cent increase in registered female domestic workers between 2002 and 2010 (from 140,000

⁸⁵ About 60–70 per cent are in facilities run by voluntary welfare organizations and the rest are in facilities run by private nursing home providers.

⁸⁶ In 2016, the Health Ministry announced that the existing 6,900 home care and 3,500 centre-based day care spaces would be expanded to 10,000 home care and 6,200 day care places by 2020 (Au-Yong, 2016).

to 201,000) (Peng, 2017, p. 16). As mentioned above, a 2010 survey found that 45 per cent of families with an older member relied on a foreign domestic worker; and, of these, 79 per cent had hired the FDW *specifically* to look after older person (Huang et al., 2012). A 2012 national survey of Singaporeans aged 75 and over found that roughly 50 per cent of these people were dependent on foreign care workers for their daily care (Peng, 2017, p. 16).

The benefits of employing a foreign domestic worker for care recipients and their families are clear. Home-based care allows patients to stay in a familiar environment. Foreign home-based nurses are paid between S\$600 and S\$1,000 a month, depending on their qualifications, which is higher than the S\$500 average monthly salary of a regular domestic worker, but far less than the salary of a local nurse, who may earn S\$6,000 a month doing 12-hour shifts in a patient's home. This cost can also be lower than nursing home fees, which range from S\$1,200 to S\$3,500 a month before government subsidies for households below an income cap (Seow, 2015).

Hospitals also draw on foreign health-care workers to fill their ranks, but the proportion is usually small, averaging 20 per cent, but not more than 40 per cent of their total nursing staff.⁸⁷ Nursing homes providing subsidized long-term (two to five years) older person care depend primarily on foreign healthcare workers, accounting for up to 80–90 per cent of their workforce, particularly at the level of enlisted nurses and below (Huang et al., 2012, p. 201).⁸⁸

Migration policies and professional recognition: Stratification of the migrant workforce: Work visas differentiate between all migrant workers entering Singapore, distinguishing highly skilled professionals (who enter under employment passes, discussed in box 2.4, subsection 2.3) from “mid-level skilled workers”, such as registered nurses (RNs), and “semi- and unskilled workers”, which include Singapore-designated positions of “enrolled nurses”, “nursing aides”, “health-care attendants” and foreign domestic workers.⁸⁹ While foreign domestic workers, health-care attendants, nursing aides and most enrolled nurses are recruited under the work permit system (box 2.4), the more highly skilled and qualified care workers earning a fixed monthly salary of at least S\$2,200 (as of July 2017) are eligible for the “S-Pass”.⁹⁰ Most of Singapore’s foreign nurses are S-Pass holders since the majority (56.5 per cent as of 2010) are registered nurses rather than enrolled nurses.⁹¹

However, upon entering Singapore to work, the process involved in registration and enrolment of foreign nurses and midwives often results in foreign nurses having to downgrade, for example from RN to enrolled nurse, or from enrolled nurse to nursing aide, if they do not meet the criteria (Huang et al., 2012). Health-care workers can, in theory, upgrade their qualifications and move from the work permit to the S-Pass. However, in practice, this process is not easy as applications to take upgrading examinations (including the Singapore nursing certificate) are dependent on employers’ approval. Employers may prefer nurses to remain in lower level jobs to keep salary costs down and prevent workers from moving to clinical jobs in hospitals once they qualify as enrolled nurses or registered nurses. Thus, some foreign nurses choose to leave their jobs as nursing aides working with 30–40 patients in nursing homes, to work as foreign domestic workers for a family with only one or two older patients.

⁸⁷ More than one-quarter of the doctors in the public health-care sector are foreigners; most are primary care doctors. At the end of 2014, public hospitals and polyclinics had more than 2,100 foreign doctors in their employ, and the number reportedly continues to grow as Singapore faces a shortage of trained medical staff (Khalik, 2015).

⁸⁸ Based on interviews with nursing homes – May 2006 to August 2007.

⁸⁹ See www.mom.gov.sg/ for more details.

⁹⁰ The “S-Pass” is an intermediate level work pass that was introduced in 2004 to make the employment of foreign mid-level skilled workers more flexible. S-Pass holders who earn more than S\$5,000 per month are allowed to bring in dependants. Further information is available at www.mom.gov.sg/passes-and-permits/s-pass/eligibility.

⁹¹ Qualifications are administered by the Singapore Nursing Board.

Without certification from the Singapore Nursing Board, many trained and experienced foreign nurses work with a foreign domestic worker work permit. Their monthly salaries may be higher than most domestic workers. There is a growing number of qualified foreign nurses in Singapore caring for patients outside hospitals and nursing homes. Their job may include taking patients through exercises, dressing wounds, monitoring vital signs, and bathing and feeding them. There are no official figures on the number of foreign nurses working on foreign domestic worker work permits, but industry estimates suggest there are at least 250 (Seow, 2015).

Based on existing research, nurses from less developed countries often experience downward occupational mobility, even though they may be deemed more skilled than their domestic work counterparts (Huang et al., 2012, p. 197). This results in them earning much lower rates of pay or being assigned to low-level tasks, such as bed-making, because their skills and prior training are not recognized. Moreover, they are more likely to be assigned the less preferred care work (such as long-term older person care) than are the nurses of the majority community.

Employment regime for foreign workers: The Employment Act, the principal regulatory instrument covering leave, working hours, pay and conditions in Singapore, covers all local and foreign workers except domestic workers, managers or executives with monthly basic salary of more than S\$4,500, seafarers and statutory board employees or civil servants.⁹² The Work Injury Compensation Act, covering indemnities for workplace injuries and accidents, encompasses all local and foreign workers except domestic workers, independent contractors and the self-employed, and uniformed personnel (Singapore Armed Forces, Singapore Police Force, Singapore Civil Defence Force, Central Narcotics Bureau and Singapore Prison Service).

Alternative legal instruments and the Employment of Foreign Manpower Act (which has undergone modifications) were developed through the course of the 1980s to 2000s to regulate the employment and working conditions of foreign domestic workers. The Standard Employment Contract between Foreign Domestic Worker and Employer (modified several times) lays out in detail certain conditions for employment, including wages and when they will be paid each month; the type of accommodation the workers will have; the minimum number of meals each worker is to receive free of charge each day; the hours of rest and number of rest days to which they are entitled and the monetary compensation in the event that those days are forgone.⁹³ A series of high-profile “maid abuse” cases and deaths (resulting from falling in escape attempts, suicide or in the course of their work) in the 1990s led to the development of regulations aimed at providing greater protection to domestic workers, such as requiring employers to take out accident insurance for their domestic workers, harsher penalties for employers convicted of abusing domestic workers, accreditation of all employment agencies, and orientation programmes for new employers and employees (Dodgson and Auyong, 2016).⁹⁴

4.1.1.3. GCC: Foreign domestic worker-specific programme

Demand for foreign domestic workers: Domestic work is the single most important occupation among women migrating for purposes of employment to the GCC countries as well as to Jordan and Lebanon. Other migrant women enter health-care and caregiving occupations. The 1973 oil boom in

⁹² See www.mom.sg/ for details.

⁹³ See www.mom.sg/ for details.

⁹⁴ Between 1999 and 2005, at least 147 migrant domestic workers died from workplace accidents or suicide, most by jumping or falling from residential buildings. Research undertaken by Human Rights Watch suggested that many women were made despondent by poor working conditions, anxiety about debts owed to employment agencies, social isolation and prolonged confinement indoors, sometimes for weeks at a time. As the authorities have acknowledged, many of the deaths were also due to workplace accidents. Several of the workers fell to their deaths after their employers forced them to balance precariously, despite being many storeys up, to clean windows from the outside or to hang out clothes to dry on bamboo poles suspended from window sills (Human Rights Watch, 2005).

the Gulf region created an unprecedented demand for labour in the oil, construction and industrial sectors, while rising standards of living for citizens of Middle Eastern countries created a demand for domestic workers in the home. This demand for foreign labour has translated into high numbers of migrants travelling to the Middle East to work as domestic workers (refer to section 2 for data).

Scholars have linked dependence on household domestic workers to the maintenance of a social order and political stability of the States – the preservation of traditional cultural norms that stress private family responsibility and maintain women’s social reproductive roles in a context of increasing wealth and transition into more modern lifestyles (Manseau, 2005). The high demand for migrant domestic workers in the region is attributable primarily to the affluent lifestyles supported by income from oil, rather than the shift to a dual wage earner economy, as has been the case in other high-income countries (Fernandez, 2014). Women’s labour force participation rates in the region have risen over the years, but they are still relatively low. Migrant workers represent a low-cost, privatized alternative to the state provision of care services for children, sick, disabled or older members of households.

For example, in Lebanon, Fakhri and Marrouch (2012) found that, on the whole, households which are urban, larger in size, female headed and relatively well-off, as reflected in their consumption and dwelling characteristics, are most likely to employ domestic workers.⁹⁵ The poorest regions (the North and Bekaa Mohafazas) had the lowest percentage of households employing domestic workers, in comparison to Beirut, the capital and richest region in the country, where the percentage was 12 per cent. From a sample survey of employers of live-in domestic workers, those hiring live-in domestic workers because the employers worked full time accounted for 31 per cent; to take care of an older person or a person with an illness or disability made up about 40 per cent; and to take care of children, 20 per cent (Fakhri and Marrouch, 2012, p. 9).

Exclusion from labour protection: Legal protection for migrant care workers is limited. Domestic workers are explicitly excluded from the labour laws of almost all countries in the Arab States region, with the partial exception of Bahrain, which only grants domestic workers a subset of rights under the labour law, and Jordan, which covers domestic workers through a specific labour law (ILO ROAS, 2017a; ILO, 2013). While some countries have separate legislation for domestic workers (including Jordan, Kuwait, Saudi Arabia and, soon, Qatar and the UAE), the standards set are commonly lower than those in the general labour law. In the absence of effective legislation, many countries in the region leave regulation of the employment relationship to the coverage of mandatory employment contracts.

The employment relations between employers and migrant workers (known as “temporary expatriate workers” in the GCC countries and Jordan and Lebanon), are governed by regulations, norms and customary practices around a form of employer-sponsorship system based on the concept of “kafala” (box 4.2). Under kafala a worker’s legal status is linked to one employer and the worker cannot unilaterally exit the employment relationship. The domestic workers’ exclusion from labour legislation and social protection exacerbates the power imbalance. The sponsorship arrangements prevalent in the Middle East severely limit migrant workers’ opportunity to leave an employer and create a number of risks of human rights abuses and labour exploitation (ILO ROAS, 2017b, p. 3).

Recent years have seen movements towards possible change. Kuwait passed Law No. 68/2015 on employment of domestic workers in 2015, which, based on its report to the ILO’s independent Committee of Experts on the Application of Conventions and Recommendations (CEACR), provides for the respective obligations of the employer and the worker, particularly with regard to the model contract issued by the Ministry of the Interior in Arabic and English. The law addresses the following issues: hours of work, remuneration and rest time, as well as holidays; expressly prohibits passport

⁹⁵ Using data from Lebanon’s National Household Budget Survey 2005.

confiscation by the employer; provides that the contract between the employer and the domestic worker is concluded for a period of two years, renewable for a similar period unless one of the two parties notifies the other at least two months before the end of the two-year contract; and gives domestic workers the right to file a complaint with the Domestic Labour Department and seek redress (ILO, 2016d, p. 197-198). Nonetheless, the CEACR noted “with concern the indications by the unions that migrant domestic workers are vulnerable to abusive practices and working conditions that may amount to the exaction of forced labour”. While the CEACR recognized that Kuwait’s Law No. 68/2015 constituted a “positive step” towards improving the protection of migrant domestic workers, the Committee urged the Kuwait Government to implement the necessary measures to ensure that it is “effectively applied”. In May 2017, the Federal National Council of the United Arab Emirates passed a new bill on domestic workers, which will come into effect once it receives presidential approval. The new bill includes reforms to protect rights of domestic workers, including access to dispute resolution, paid annual leave and minimum hours of daily rest, and regulate relations between employers, employees and recruiters (*Gulf News*, 2017).

Bilateral labour agreements signed by GCC countries generally focus on pre-departure requirements, regulation of the recruitment process, provisions relating to payment of salaries, content and form of the employment contract, methods for resolving disputes and frameworks for monitoring the agreements (Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and ILO, 2015, pp. 23–26). These agreements normally represent an improvement on the status quo but, like standard employment contracts, offer fewer and weaker protections than those enshrined in national labour laws, and have unclear enforcement mechanisms and penalties (see further discussion in section 5).

Working conditions: Many migrant domestic workers enjoy decent work conditions and positive migration experiences. However, the absence of national legal frameworks that effectively recognize and protect domestic rights in these countries facilitates abuse and exploitation, offering domestic workers who encounter such abuse few or no means for seeking redress. Estimating the prevalence of abuse is difficult, given the lack of reporting mechanisms, the private nature of the work, the lack of legal protections and restrictions on domestic workers’ freedom of movement. However, there are many indications that human rights violations are widespread (Human Rights Watch, 2010). The nature of abuses has been well-documented by media reports and studies: exploitative working conditions, including excessively long working hours, lack of rest days or rest periods, poor living accommodation, restrictions on freedom of movement and association, withholding of workers’ passports, sub-minimum wages and non-payment of salaries.⁹⁶

Box 4.2. GCC: Foreign domestic workers and the kafala system

The sponsorship systems which allow the temporary employment of non-nationals in the GCC countries, as well as Jordan and Lebanon, have historically been based on the concept of kafala, which in classical Arabic has connotations of “guarantee”, “provide for” and “take care of”. The modern use of the kafala system appeared in GCC countries during the 1960s and 1970s, when it was developed as a means to regulate the entry of migrant labour in the GCC countries of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates. Under kafala, a migrant worker’s immigration and legal residency status is tied to an individual sponsor (kafeel) throughout his or her contract period in such a way that the migrant worker cannot typically enter the country, resign from a job, transfer employment or leave the country without

⁹⁶ The ILO supervisory bodies have also raised concerns about these issues, see *ILO General Survey on the Fundamental Conventions*, 2012, paras 256, 290, 295 and 942.

first obtaining explicit permission from his or her employer. This is distinct from most other sponsorship regimes, where only the migrant worker's employment status is determined by the employer at the time of entering the country and where more flexibility to switch employers is permitted without losing immigration status.

Although it is important to recognize that there are many sponsors who do strive to provide decent and respectful working conditions, the modern functioning of kafala is inherently rife with opportunities for employers to violate the fundamental human rights of the migrant workers under their sponsorship. Through kafala, migrant workers are placed in a position of vulnerability and have very little leverage to negotiate with employers, given the significant power imbalance embedded within the employment relationship. Common grievances expressed by migrant workers include restrictions on free movement, confiscation of passports, delayed or non-payment of salaries, long working hours, untreated medical needs and violence – all conditions that can give rise to situations of forced labour and human trafficking.

The most problematic feature of kafala is the delegation or “outsourcing” of responsibility by the State to the private employer to oversee both a migrant worker's immigration and employment status. Through the linking of residence and work permits, a migrant worker's immigration status is dependent on the contractual relationship with the sponsor. If the employment relationship is terminated, there is no longer a legal basis for the migrant worker to stay in the country. As the “owner” of the permit, the sponsor is given authorization to exert far-reaching control over the lives of migrant workers employed by them, making this employer–worker relationship much more asymmetrical than is common in a normal labour market situation.

The CEACR, in its observations with regard to the application of the Forced Labour Convention, 1930 (No. 29), has noted the vulnerability of migrant workers who are employed under the “kafala” sponsorship system in certain countries in the Middle East to forced labour conditions (observations on Kuwait, Lebanon, Qatar, Saudi Arabia, ILO, 2015c, 2016d). The Committee has urged governments “take the necessary measures, in law and practice, to ensure that migrant domestic workers are fully protected from abusive practices and conditions that amount to the exaction of forced labour” (observations on Lebanon, Qatar, ILO, 2016d).

Source: ILO ROAS, 2017b, p. 3; ILO, 2015c, pp. 167, 169; ILO, 2016d, pp. 197-199, 210-211.

4.1.2. PUBLIC SERVICES MODEL

4.1.2.1. Sweden: Universal rights to care and gender equality

Care regime: In Sweden, care for children and older persons is based on universal rights, extensive and generous. Social services for children, older and disabled persons are financed through taxes and are, to a large extent, publicly organized. Access to social benefits and services is based on citizenship rather than on income or previous labour market participation. The degree of defamilialization is high, which means that much of the care work is performed outside the family.

Childcare: Most services of the childcare and early education systems are delivered by public providers and privately run services, heavily subsidized by public funds. Childcare includes the universal right to attend pre-school from the age of 1 to 6 years old, and after-school centres up to the age of 13. Pre-schools, 10 per cent of the cost of which is covered by parents' contributions, are widely used; in 2012, 84 per cent of all children between the ages of 1 and 5 were enrolled in pre-school (Hobson et al., 2015). Many pre-schools have extended their hours beyond the normal day schedule (6:30 to 18:30) in order to accommodate shift workers, including nights and weekends. Fees are proportional to parental income and are capped. Children from the age of 3 receive 525 hours of pre-school a year free of charge (Plantenga et al., 2013, p. 71). The system is complemented by paid parental leave benefits that provide 480 days for each child (Plantenga et al., 2009, p. 61).

Many of those employed in the childcare profession are teachers, who receive education and pay comparable to their counterparts in the primary school system (Morgan, 2005, pp. 255–256). Pre-schools are staffed by pre-school teachers and childminders. Swedish pre-school and primary school teachers both attend university for three-and-a-half years, while childminders have completed a three-year secondary school programme, which trains them to work with young children. Wages paid to childcare workers are close to, if not more than, the average wages paid to all Swedish women. Union pressure has ensured that a cheaper, less skilled workforce does not undercut those who have invested in more training, so both types of worker are hired in equal numbers and receive similar pay and do many tasks together. These requirements imply high barriers to entry into formal childcare jobs.

Significantly high hourly labour costs of pre-schools also make it harder to sustain a market for private services. Family day-care centres provide a less costly option as these rely on lower-skilled workers. Paid as city employees since 1960s, employees of family day-care centres receive lower wages than workers in the formal childcare centres. They are not required to have university or secondary school training in childcare, although they must complete the training offered by municipalities.

Older person care: The Health and Medical Services Act of 1982 ensures residents equal access to health care, while the Social Services Act provides for social services to people who are particularly vulnerable or experiencing difficulties, including support for people with disabilities and care of the elderly. Both laws ensure that older people have the right to receive public services and help at all stages of life (WHO, 2017b; OECD and EC, 2013). Local municipal taxes finance about 85 per cent of long-term care (LTC) services; government grants to the municipalities cover 11–12 per cent of the LTC costs; and the remainder is financed through user fees (3–4 per cent) (OECD and EC, 2013). The level of user co-payment is capped and is based on income. In 1992, a major reform (the so-called Adel reform) gave municipalities the main responsibility for older person care and provided financial incentives to reduce hospitalization of older persons (OECD and EC, 2013). Owing to its decentralized nature, the organization of older person care is heavily dependent on local municipal socio-political traditions, economic and political contexts, so there are large differences in the expenditure per capita for older person care between municipalities and correspondingly large differences in its provision at the local level (Jönsson et al., 2011, p. 5). Municipalities are obliged to offer nursing home places and home care at income-adjusted rates, with a regulated maximum price. Services offered may include home-help services, such as cleaning, washing, shopping, etc., special housing, home medical services, meals on wheels, personal safety alarms, home adaptations and transportation services. Day-care centres for older persons are available. The municipalities are responsible for supporting families, such as giving benefits to relatives who provide home medical care and care allowances for home care, while economic benefits for family care providers, i.e. benefits that replace remuneration from labour market participation, are handled by the local social insurance office. Municipalities also organize different kinds of relief for relatives, such as short-term care and daily activities for older persons.

Nonetheless, the scope of publicly funded older person care in Sweden has diminished over the years. The supply of nursing homes has been limited in the past five years and there has been an increase in the number of older persons living longer in their own homes rather than in nursing homes. Only 5 per cent of older persons over the age of 65 live in nursing homes, while 12 per cent of the same age group have publicly subsidized home care and help (Hobson et al., 2015). With the introduction of leaner municipal budgets, services for older persons have been reduced and those on low incomes increasingly refrain from accessing subsidized home care/home help due to its high costs and rely instead on help from kin. Older persons with adequate incomes have turned to the private market for additional or complementary personal and household services (domestic work), which cost less than the subsidized home care option, with the help of a tax subsidy.

Role of personal and household services (domestic work): The private market for home-based personal and household care services was stimulated by a tax subsidy that made it more affordable for private households (generally those on a higher income) to hire a domestic worker. Introduced in July 2007, the *RUT-avdrag* tax reduction on domestic work is a means to transform undeclared work into declared work, create job opportunities (especially for the unemployed and people with low qualifications) and contribute to the reconciliation of private and professional life (EFSI, 2013; Hobson et al., 2015).⁹⁷ Users benefit from a 50 per cent tax reduction of labour cost for services performed in the taxpayers' home or in their parents' home and purchased from a registered company or a self-employed person (EFSI, 2013). Possible services are cleaning, window-cleaning, gardening, snow clearing, washing clothes, cooking, childminding and basic personal care services. Note, however, that private care/domestic services are not affordable for all families in Sweden, and the RUT subsidy is not a universal benefit. Thus, childminding is a marginal part of the market, and relatively high-income older persons are overrepresented as buyers of cleaning services. According to one report (Hobson et al., 2015, p. 10), 35 per cent of the buyers are over 65 years old and the services are mainly used by the group over the age of 85 years old. EFSI (2013, p. 30) also reports that, in 2011, it appeared that 68 per cent of the RUT users had a general monthly income of 32,000 Swedish krona (SEK) or less. Moreover, the domestic sector is dominated by firms who employ workers and provide their services to households; workers directly employed by households constitute a minority (Hobson et al., 2015).

Migration regime: Until the introduction of the new immigration law of 2008, there was little economic immigration to Sweden; most permits were granted to asylum seekers and for family reunification. The 1968 Immigration Act set a rather restrictive migration regime. It required work permits for all labour immigrants. The employment situation and the availability of housing, education, health care and other services determined the extent of labour immigration. Labour immigration was also only to be allowed in exceptional cases. After a peak in 1970 (77,000 persons), labour immigration from countries outside the region more or less halted. Nevertheless, labour immigration from the other Nordic countries continued, but at a lower level.⁹⁸ As a consequence, Sweden's labour market has been more or less closed to non-Nordic labour migrants from 1972. Temporary labour immigration has constituted the smallest percentage of all migration types since the 1970s.⁹⁹ It should be noted that temporary work permits were issued for all skill levels, but were granted mostly to experts and key people in industry, research, culture and sports. Sweden's demand for older person care or a long-term care workforce has only partly been met through migrants who had originally come to the country for reasons other than work (e.g. asylum, family reunification or training) (Hobson et al., 2015).

Since the expansion of the European Union in 2004, labour immigration has begun to increase, with Poland as one of the main countries of origin. In 2008, a new immigration law liberalized the migration regime and it became easier for both low- and high-skilled workers to obtain a work permit

⁹⁷ In the EU, the development of "personal and household services" has been considered an important strategy for creating jobs, especially for the low-skilled and the long-term unemployed, while simultaneously responding to unmet social needs, especially with respect to childcare and older person care, but also with respect to the needs of increasingly time-pressed dual-earner families or single parents who struggle to combine paid work with family life and household tasks, such as cleaning, cooking, etc. Promoting greater freedom of choice in terms of the services available to individuals, not least for older persons, has also been highlighted as a reason for encouraging the development of domestic services. Last, but not least, the development of personal and household services has been put forward as a desirable solution to meet the increasing demand for long-term care under increased budget constraints (Hobson et al., 2015; EFSI, 2013).

⁹⁸ The Nordic passport control agreement, which came into force on 1 July 1954, granted citizens of Nordic countries the right to live and work freely in other Nordic countries.

⁹⁹ It was different in the 1950s to 1970s, when Sweden implemented significant guest worker programmes to meet labour shortages. Temporary workers came from the Nordic countries and several other countries (see Cerna, 2009).

in Sweden, and for students and asylum seekers to stay in the country.¹⁰⁰ Migration was made more employer-driven. Heavy sanctions are imposed on irregular immigration and informal employment, so migrants in an irregular situation are pushed into clandestine, precarious work (Hobson et al., 2015). According to trade unions, the new immigration law has led to a growing pool of low-paid migrant workers in Sweden, and a dramatic increase in illegal trade of work permits as a “window of entry” into Sweden when the asylum channel is not applicable (Hobson et al., 2015).

There are few data about undocumented migrants in Sweden but available reports indicate that they are increasingly present in low-wage and informal segments of the Swedish labour market. In 2011, a government report estimated that there were “not more than 35,000” undocumented migrants living in Sweden (SOU, 2011, cited by Hobson et al., 2015, p. 13). The Trade Union Centre for Undocumented Migrants in Stockholm estimates that there are 50,000–75,000 undocumented migrants in Sweden (Hobson et al., 2015, p. 13). There are reports stating that these migrants generally work as cleaners, in hotels and restaurants, shovel snow from inner-city roofs, pick berries, pile products in commercial establishments, demolish and clean in construction sites and work as taxi drivers (Selberg, 2012). Migrants are also increasingly present in domestic work.

Stratification in older person care and domestic work: The expanding private markets for care/domestic services have resulted in greater stratification of the care workforce. In Sweden, the domestic sector consists of several tiers (Hobson et al., 2015, p. 18). At the upper end are those doing domestic work for older persons, employed by the public sector in municipalities, either directly or outsourced from a public sector agency. They have better pay and working conditions than the strictly private market. A greater proportion of Swedish-born workers are attracted to these jobs compared to those working in private firms (the second tier). In the second tier, private firms mainly employ migrants, who may be performing many of the same tasks for older persons as outsourced workers employed via the municipality but who are paid lower wages and have more insecure jobs. The bottom layer consists of those in undeclared, irregular employment, the majority of whom are undocumented migrants who have the worst employment conditions, paid half or less than the standard wage in the sector.

A small number of interviews with migrant domestic workers in Stockholm (Hobson et al., 2015) yield insights into their living and working conditions (box 4.3).

Employment regime for migrants in regular and irregular situations: Legally recognized immigrants largely have the same rights as citizens, with the exception of some political rights (such as voting rights). In terms of access to social rights, the main boundary is instead drawn between immigrants with residence permits (ranging from temporary to permanent) and undocumented migrants (Hobson et al., 2015). It is, however, important to note that legal residence may be a temporary and weak status, as permits may not be renewed unless a valid job contract can be presented.

Since July 2013, undocumented migrants have the same right to basic health care as recognized asylum seekers, which includes urgent health care, maternity care and birth control. Undocumented children were also granted the right to schooling. But it should be noted that access to public health care for undocumented migrants has been a highly politically contentious issue over the past decade (Hobson et al., 2015, p. 14).

¹⁰⁰ The new law states that an applicant (outside the EU/EEA area) for a work permit must have an offer of employment from a Swedish employer. The job must have been advertised in Sweden and the EU for ten days. The terms of employment must be equal to or better than those provided under a Swedish collective agreement or that customary for the occupation or industry, and the employee must earn enough from employment to support himself/herself. The scope of the work must be such that the monthly wage is at least SEK 13,000 before tax. The relevant trade union must have been given the opportunity to express an opinion on the terms and conditions of employment (Cerna, 2009).

Box 4.3. Some findings from interviews with migrant domestic workers in Stockholm

There are both documented migrants and migrants in an irregular situation working at the same firms, as well as documented migrants working partly formally and partly informally. These practices are more likely to be found in small firms, which comprise a large proportion of the sector. Informal work in the domestic sector is not confined to any one migrant group; it cuts across different nationalities and migrant statuses, although migrant status is, overall, a crucial divide in Sweden. Firms are able to claim the RUT tax deduction while subcontracting workers informally and therefore avoid paying social contributions.

Having a formal contract makes a difference to one's access to employment rights and protections, such as paid vacations and sick leave, and unemployment benefits. However, in practice, labour rights, such as sick leave and vacations, are not always taken up. Many do not take vacations but instead receive extra pay, which is standard practice for hourly workers, the most common employment form among the Stockholm interviewees. Several did not take sick leave because of the competition for jobs in firms.

The wage difference between documented and undocumented workers is striking. Those without legal papers are paid about one-half to one-third of the wages compared to workers with residence permits.

Workers employed on an hourly basis lack job security and predictability in terms of the number of work hours. The standard practice in the sector is unpaid transportation time, which can be long due to the significant commuting distances – a major concern for workers. Work hours are often far from sufficient, placing particularly those workers who depend on this income for their maintenance in a very precarious position.

The overhanging threat of deportation and the inability to go to the police means that migrants in an irregular situation in Sweden are easily exploited. Several respondents, who have experienced working without a legal permit in Sweden, have been sexually harassed at work and denied payment after a job is completed.

Individual factors, including language skills, age and ethnic hierarchies, play a role in the employment situation. Results from a buyer survey in Sweden shows that clients prefer to buy cleaning services from Swedes, followed by other Europeans and a hierarchy of mostly non-Europeans at the end of the spectrum. Observations made by workers in Stockholm note that Polish claim to have a reputation for being the best cleaners and that “when they [clients] hear that there is a Pole in the team, they are more eager to cooperate [with the firm]”. Several workers state that Swedes get better working conditions than migrants – they get paid more and face lower demands from the firms.

Source: Hobson et al., 2015.

4.1.2.2. Canada: Mixed public–private care and caregiver programme

Care regime: Canada has a government-run, publicly funded (from general taxes) health insurance system under the Canada Health Act, which covers the entire population for “medically necessary” services, i.e. if provided in hospital or by “practitioners” (usually physicians).¹⁰¹ Care services by non-physicians outside the hospital are not insured. Services such as mental health, vision care, rehabilitation and drug coverage, residential long-term care, home care, adult residential care and

¹⁰¹ *Canada's health care system*, the Government of Canada, 2016, <https://www.canada.ca/en/health-canada/services/canada-health-care-system.html> [accessed 26 Sep. 2017].

ambulatory health services are not insured either, but are funded through the Canada Health and Social Transfer Act.¹⁰²

Once health care moves beyond the services provided under the Canada Health Act, important differences from province to province (or territory), in terms of what services are covered by public insurance, emerge.¹⁰³ Most provincial and territorial governments offer and fund some supplementary benefits for certain groups (e.g. low-income residents and older persons), but this depends on the specificities of their public insurance plans. On the whole, supplementary health services are largely financed privately (by out-of-pocket, employment-based group insurance plans or private insurance). In 2010, approximately 71 per cent of health-care expenditures were financed from public sources (provincial and territorial government plus federal fiscal transfers), 24 per cent from private sources and the rest from various sources (social security, municipal government, federal direct).¹⁰⁴

In brief, Canada does not have a universal approach for the care of older persons who are at significant risk of having progressive and/or chronic conditions, and who require services to meet their long-term functional needs.¹⁰⁵ As a result, each province has developed its own terms and conditions under which services outside the Canada Health Act are provided. Regional disparities exist in respect of the types of services and funding available to older persons. This is a serious issue because the demand for long-term care in Canada has grown due to the ageing of the Canadian population and the increased preference among older persons to “age in place”, as well as changes within the health-care system (Bourgeault et al., 2009).

Reforms to the health-care system have shifted the locus of care from expensive acute care institutions into less expensive long-term care facilities and community- and home-based settings (Bourgeault et al., 2009). The main components of long-term care (LTC) service delivery systems in Canada are home care and community-based services, and institutional LTC facilities. An older person can procure home care services in different ways, depending on the province – care may be delivered by public employees, by a combination of publicly employed professionals and for-profit and non-profit home-care agencies which have been contracted to provide services, or by a combination of for-profit and non-profit agencies chosen to deliver service. Institutional LTC facilities are chronic care hospitals (or chronic care units within hospitals)¹⁰⁶ and nursing homes or homes for older persons

¹⁰² The Canada Health and Social Transfer (CHST) was a system of block transfer payments from the Canadian Government to provincial governments to pay for health care, post-secondary education and welfare, in place from the 1996–97 fiscal year until the 2004–05 fiscal year. It was split into the Canada Health Transfer (CHT) and Canada Social Transfer (CST), effective April 2004. The CHT is the largest major federal transfer to provinces and territories; provides long-term predictable funding for health care and supports the principles of the Canada Health Act. The CST is a federal block transfer to provinces and territories in support of post-secondary education, social assistance and social services, and early childhood development and early learning and childcare. It is calculated on an equal per capita cash basis to reflect the Government’s commitment to ensuring that conditional transfers provide equal support for all Canadians. An assessment of CST concluded that the funding provided through the Canada Social Transfer is insufficient to meet most provincial spending on just income assistance, and that it falls even more drastically short of the actual funding that would be required to provide adequate social assistance, social services, childcare and early childhood education, and post-secondary education (Duncan and van Draanen, 2013).

¹⁰³ Publicly funded insurance is organized at the level of the province and territory, the system consists of 13 provincial and territorial health-care insurance plans.

¹⁰⁴ *Canada’s health care system*, the Government of Canada, 2016, <https://www.canada.ca/en/health-canada/services/canada-health-care-system.html> [accessed 26 Sep. 2017].

¹⁰⁵ This is also the case with childcare –the federal government, provinces and territories have different jurisdictions as regards to early childhood education and care, each with its own approach to various issues, from fees and staff training to monitoring. Within each province, parents are faced with “a disparate and often confusing array of options, from informal arrangements, to unregulated in-home day care, to licensed, community-based centres” (Johnson, 2017). Good quality, licensed care in Canada (with the exception of Quebec) is expensive; parents usually pay the bulk of the cost of care.

¹⁰⁶ Chronic care hospitals or units provide care to persons who, because of chronic illness and marked functional disability, require long-term institutional care but who do not require all of the resources of an acute, psychiatric or rehabilitation hospital. There is 24-hour coverage by professional nursing staff, care by on-call physicians, as well as care by other health and social specialists.

that provide multiple levels of care to clients who can no longer live at home. Challenges facing the system are funding for home and community care which has not increased along with the increasing demand; and recruitment and retention of professional and care support staff for home care and residential/nursing home care. Issues of “casualization” of nursing and home support jobs, and low levels of remuneration compared to hospital care, have made these jobs less attractive than jobs in other health-care sectors.

Migration regime: Canada is one of the few countries in the world which has implemented an active programme for permanent immigration; most immigrants come as permanent settlers.¹⁰⁷ The Canadian public, as well as the major political parties, have supported sustaining or increasing the current level of immigration (Rahim, 2014; Freeman et al., 2013). In the past two decades, temporary labour-related migration has also been quite actively taken up, with increased movement of foreign workers, of which care workers (individuals paid to provide paid care to children, older persons, persons with a disability and the sick, and including nurses and in-home caregivers) have been an important group (Salami et al., 2016). The main programmes which have facilitated migration of care workers to Canada include the Canada Caregiver Program (CCP) and its predecessor, the Live-in Caregiver Program (LCP), Canada’s Temporary Foreign Worker Program (TFWP), International Mobility Program, the Provincial Nominee Program and the newly created Canadian Express Entry System.¹⁰⁸

The TFWP has been used to meet short-term labour shortages in skilled and low-skilled sectors. Until a few years ago, the numbers of people who entered Canada through the TFWP were significant (Bourgeault et al., 2009; Salami et al., 2016).¹⁰⁹ This trend was curtailed by migration policy changes in the TFWP in 2011–2015. Evident in these changes was an emphasis on the class of temporary foreign workers, given the unequal treatment of low-wage workers, and the disposability of low-wage foreign workers. In 2011, a “four-in, four-out” rule was introduced, which made certain foreign workers ineligible to work in Canada for four years upon completion of four years of work in Canada. This resulted in the expiration of work visas for 25 per cent of migrant workers on 1 April 2015 (Salami et al., 2016). Furthermore, in June 2014, the federal government announced an overhaul of the programme with the following effects: limiting the length of time that temporary foreign workers are allowed to remain in Canada; a differentiation of temporary foreign workers by wage level (rather than skill level) and a shift in priority towards recruiting high-wage (high-skilled) foreign workers; capping the number of low-wage workers; and limiting access of low-wage migrant workers to Canadian permanent residency.

The current Canadian administration, however, quickly reversed these changes made by the previous administration (CIC News, 2016b).¹¹⁰ Among the key changes to the TFWP, the “four-in, four-

¹⁰⁷ One can be admitted into Canada as a permanent immigrant through family sponsorship, humanitarian resettlement and refugee protection schemes, or for economic reasons based on the individual’s capacity to make a contribution to the Canadian economy (e.g. skilled workers, investors, entrepreneurs, self-employed persons).

¹⁰⁸ The TFWP allows foreign nationals to migrate temporarily to Canada. The International Mobility Program, introduced in 2015, comprises all streams of work permit applications that are exempt from obtaining a labour market impact assessment prior to migrating to Canada. The Federal Skilled Worker Program (introduced in 2015), with the newly created Express Entry immigration processing system, is the main permanent migration stream for immigrants to Canada, including nurses. Individuals migrating through this route must meet minimum requirements based on six selection factors: language, education, work experience, age, evidence of valid job offers and adaptability. They must also demonstrate proof of sufficient funds.

¹⁰⁹ More than 192,000 temporary foreign workers entered Canada in 2011. The overall total included about 70,000 foreign workers whose employer required a labour market opinion (LMO) and close to 120,000 for whom an LMO was not required. In 2011, more than 29,000 temporary foreign workers made the transition to permanent status. Source: Fact sheet: Temporal foreign worker program, the Government of Canada, 2015, <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/fact-sheet-temporary-foreign-worker-program.html>.

¹¹⁰ Also see Canada’s Immigration webpage «Canada’s Temporary Foreign Worker Program: New Changes Announced (Audio)» at <https://www.immigration.ca/canadas-temporary-foreign-worker-program-new-changes-announced/> [accessed 26 Sep. 2017].

out” rule was abolished and elimination of the Labour Market Impact Assessment fee, for families seeking caregivers for persons with high medical needs and for families earning less than 150,000 Canadian dollars (\$) seeking childcare, is planned. Moreover, Canada’s 2017 federal budget allocated nearly \$280 million over five years to delivering and improving the TFWP and the International Mobility Program. Canada’s 2017 immigration plan promises a high intake of immigrants through the economic and family sponsorship programmes (CIC News, 2016a).

Foreign-born, foreign-educated nurses: Nurses play a crucial role in the skilled workforce providing Canada’s health care and long-term care. The admission of foreign-born or foreign-educated nurses follows periods of labour demand/shortages.¹¹¹ In general, nurses born and trained outside Canada experience several barriers to obtaining the professional certification to practise in Canada and to integrating into the health-care system: credential recognition and assessment, cyclical changes in immigration and nursing policy, meeting the language and nursing examination requirements and costs that these entail.

The former LCP and the current CCP have provided a path for internationally educated nurses to migrate to the country, though with limited rights. The data on their numbers are quite disparate, but various studies point to the fact that there is a considerable proportion of live-in caregivers who have a health-care qualification or nursing degree.¹¹² There are nurses who came through the LCP because they could not have their foreign credentials recognized in Canada (Bourgeault et al., 2009).

Canada’s Caregiver Programmes: The LCP, implemented for more than two decades, was replaced in 2014 by the CCP. See box 4.4 for the main features of the programmes. The LCP had a precursor, the Foreign Domestic Worker Movement, established in 1981. The change in nomenclature reflects the shift in care needs and the type of work to be performed, from a broader set of household tasks to caregiving exclusively (Fudge, 2012). However, unlike its predecessor which enabled families to hire foreign employees to meet childcare and household needs, the LCP was meant to supply qualified live-in home support workers for older and disabled people. In this regard, it is important to note that Canada does not have, as in the case of long-term care for older persons, a universal approach and programme to support childcare. Childcare has to be provided unpaid by the family and/or outsourced to paid childcare services (such as day care and crèches), which are costly.¹¹³

In spite of being cited as “best practice”, because the LCP offered a path to permanent residency, it has received criticisms. The main ones are the live-in requirement of the LCP, and the link (like other TFWPs) between the migrant worker’s entitlement to work in Canada and an ongoing employment relationship with a specific employer. These increase the worker’s dependency on a single employer and therefore increase the possibility of abuse of migrant workers by employers, employment agencies and immigration consultants. While certain features of the new CCP may be viewed positively, some have argued that the new immigration controls have made the status of migrant care workers more

¹¹¹ For example, after a restrictive policy in 2011–2015, the current policy supports the TFWP. There is also a huge demand for foreign nurses across Canada, and especially in Quebec (Watt, 2014).

¹¹² Salami et al. (2016) maintain that there is well-documented evidence that live-in caregivers are often encouraged by recruiters to falsify the information they provide to immigration officials, including regarding their qualifications. Salami et al. (2016) cited various sources for data: one survey noted that 23 per cent of live-in caregivers had a health-care qualification, while only 7 per cent had a nursing degree. Data obtained from the Citizenship and Immigration Canada (CIC) website on a doctoral study indicated that only around 1 per cent of live-in caregivers had a nursing degree. A survey of 75 migrant care workers across Canada providing low-skilled older person care, including live-in caregivers and personal support workers, showed that 44.12 per cent were nurses prior to migrating to Canada.

¹¹³ See current articles: Johnson, 2017; Cossette, 2017.

insecure and vulnerable to accepting unfavourable working conditions (Salami et al., 2016; Fudge, 2012; Stasiulis and Bakan, 1997). These issues revolve around four aspects of the programme:

- First, although the CCP provides two pathways (as opposed to only one in the LCP) for migrant care workers to enter Canada and seek permanent residency, the CCP places a cap on the number of caregivers whose application for permanent residency status will be accepted per year. This ceiling, on top of more stringent eligibility requirements, makes permanent residency harder to achieve and puts migrant care workers in an insecure and vulnerable position. Their employment is tied to their ability to obtain permanent residency status.
- Second, while the CCP removed the obligation on caregivers to co-reside with the employer, which created a context for abuse and exploitation, it is not clear that this has improved the situation of home-based caregivers. As long as one's work permit is tied to a particular employer, the care worker may be offered little choice. At the same time, the care worker's wages may not be sufficient to pay for his or her own residence.
- Third, workers often lose their status because employers are unable or unwilling to retain them as employees. Finding a new employer to maintain one's status under the programme can be a long and difficult process. Some caregivers claimed that obtaining a work permit is harder than before: labour market assessments (required before the Government approves an employer application to employ a care worker and issue a work permit) take six months to complete whereas this process previously took only two to three months; employers of care workers should have a higher income and pay higher fees.
- Fourth, recruitment agencies have been implicated in the exploitative and abusive experiences of migrant caregivers – they often misinform migrant caregivers about the ease of gaining permanent residence status or access to the nursing profession in Canada and commonly charge high fees, supposedly for permanent migration, with no guarantee that migrants would receive this status. There have been cases of human trafficking, sexual exploitation and practices akin to slavery by recruitments agencies. Moreover, there is little recourse for migrants when their rights are violated. Not all caregivers entered the CCP through agencies, but among caregivers and employers who were interviewed by Bourgeault et al. (2009) there was a general lack of confidence in agencies.¹¹⁴

In brief, the migrant worker's paramount vulnerability is therefore not so much the living arrangements as the temporariness and precariousness of employment and residency rights. Since the implementation of CCP in 2014, and as of 2015, the number of migrant caregivers entering Canada through this care-specific programme has declined by over 90 per cent; only 10 per cent of migrants who apply to the CCP are accepted (Tungohan, 2015, cited by Salami et al., 2016, p. 4). Many factors combine to dissuade workers from applying: the cost to an employer for a Labour Market Impact Assessment more than tripled in June 2014; there is a new English or French language requirement (equivalent to Canadian Language Benchmark 5 for childcare workers or Benchmark 7 for registered nurses); maximum quota for admissions; in general, greater barriers to finding an alternative employer for caregivers who face abuse.¹¹⁵

¹¹⁴ Some workers were hired directly by their employers. Informal networks and contacts were used to find jobs/workers.

¹¹⁵ Ibid. <https://www.youtube.com/watch?v=wVFR1xfpXrk>. As of 1 December 2012, there were 338,221 temporary foreign workers in Canada (Salami et al., 2016, p. 1).

Box 4.4. Canada's Live-in Caregiver Program and Caregiver Program**Live-in Caregiver Program (LCP)** – Implemented 1992–2014

This programme was a special stream of the general TFWP, designed to fill a specific labour shortage in Canada, i.e. the lack of people willing to reside in private households and provide care to members of those households. Families could hire foreign caregivers to provide older person care, childcare and care for persons with disabilities in a private residence. Unlike other temporary worker programmes, it required the migrant worker to live in the private household of the care recipient. The quid pro quo was that it provided a unique pathway to permanent residency. Live-in caregivers were eligible to become permanent residents in Canada after a minimum of 22 months of work in Canada.

LCP was employer-driven and it tied the migrant worker's entitlement to work in Canada to an ongoing employment relationship with a specific employer. The requirements for prospective employers included having sufficient income to pay, acceptable accommodation and covering all recruitment costs. Live-in caregivers could work only for one employer at a time. A caregiver who resigned or was dismissed had to find another employer with an offer of employment validated by the appropriate Canadian agency, and then obtain a new federal work permit, which could take up to a month, during which time the caregiver was not allowed to work. Over 90 per cent of foreign nationals who entered Canada under the LCP applied for permanent residence status, and 98 per cent of them were successful.

Canada Caregiver Program (CCP) – Introduced in 2014, current.

The CCP allows caregivers (including health professionals, nannies and low-skilled caregivers) to migrate to Canada to provide care to either children or individuals with high medical needs. The programme removed the live-in requirement for caregivers but required a two-year residency in Canada and specific eligibility requirements (educational qualifications and a language test) to gain the right to seek permanent residency. It provides two pathways – childcare and health care – but each pathway is capped at 2,750 places per year. Caregivers who migrate under this stream can choose to live-in or live out of the employer's home. They are eligible to become permanent residents in Canada after a minimum of two years of work in Canada. They must meet specific language requirements prior to being eligible to become permanent residents in Canada.

Source: Fudge, 2012; Salami et al., 2016.

Labour protection for domestic workers and migrant workers: Historically, domestic work has been excluded from Canada's statutory employment standards, such as those governing overtime and statutory holidays. However, this pattern of exclusion has been changing and domestic workers, who include live-in caregivers, are now covered by most employment standards (Fudge, 2012, p. 108). Jurisdiction over migrant workers in Canada is divided between the federal government, which has primary jurisdiction over immigration, and the provinces and territories, which have responsibility for employment and labour law and policy (Fudge, 2012, p. 103). Thus, at the federal level, the TFWP is governed by a complex and flexible network of legislation, regulations, manuals and guidelines administered by several government departments and agencies.

For example, in Ontario, domestic workers hired by private households have the same rights as other employees in Ontario workplaces under its Employment Standards Act 2000 (ESA) which sets minimum requirements for employment, but they are excluded from collective bargaining and

occupational health and safety legislation (Ontario Ministry of Labour, n.d.).¹¹⁶ “Domestic workers” are defined under the ESA as those employed directly by householders, and not by a business or agency, to carry out work in a private home, such as housekeeping, or to provide care, supervision or personal assistance to children, older persons or those who are ill or disabled. An employee who is hired by a business, agency or any person other than the householder (i.e. a person who owns or rents the home where the domestic work is done) to perform homemaking services for a householder is classified as a “homemaker” and is subject to special rules and exemptions under the ESA. Ontario’s ESA generally applies to temporary foreign workers. But a domestic worker who is also a foreign national working or who is seeking work in Ontario “pursuant to an immigration or foreign temporary employee program” is *also* covered by the Employment Protection for Foreign Nationals Act (EPFNA) 2009 (Ontario Ministry of Labour, n.d.).¹¹⁷

Working conditions: In spite of generally good relations between older person care workers and employers, there are issues with regard to working conditions and employment relations in care settings for older persons. Field interviews carried out by Bourgeault et al. (2009) pointed to some of these:

- (i) Employers tend to allocate less favourable or less desirable aspects of the work to migrant workers; namely, heavier workloads, more difficult patients, Sunday shifts, fewer shifts if there is less work to do (resulting in less income for part-time workers).
- (ii) Migrants in long-term care and home-care settings tend to experience a high level of isolation, both at home and at work, due to busy or irregular work schedules.
- (iii) Live-in caregivers experience a great amount of additional work and responsibility. They are expected to work practically all day and night, and to take total responsibility for the care of the client, whose family often resides far away. They are also frequently exposed to unreasonable demands, such as doing other household work beyond their job description and to sexual harassment.
- (iv) The workload in nursing homes is very heavy due to patients’ demanding care needs and shortages of staff and supplies.
- (v) Problems concerning working through agencies include the part-time nature of the job, which could mean working fewer hours, irregular and on-call work.
- (vi) Tensions between employer and migrant caregiver, and between migrant and native-born caregivers arise due to differences in language (including accents) and in ideas of how care is to be delivered. Some employers think that migrants require additional training for the job, while some caregivers are overqualified but unable to have their foreign credentials recognized.

¹¹⁶ The ESA contains rules on the following: minimum wage, regular payment of wages, hours of work protections (e.g. maximum hours of work, daily and weekly/biweekly rest periods), overtime pay, vacation with pay, public holidays, pregnancy and parental leave, personal emergency leave (applies only to employees whose employer regularly employs at least 50 employees), family caregiver leave, family medical leave, critically ill childcare leave, organ donor leave, reservist leave, crime-related child death or disappearance leave, termination notice and/or pay in lieu of notice, severance pay and equal pay for equal work.

¹¹⁷ The EPFNA 2009 (effective 2015) prohibits recruiters from charging foreign nationals any fees, either directly or indirectly; generally prevents employers from recovering or attempting to recover from the foreign national any cost incurred in arranging to become the foreign national’s employer; prohibits employers and recruiters from taking a foreign national’s property, including documents, such as a passport or work permit; prohibits a recruiter, an employer, or a person acting on their behalf from intimidating or penalizing a foreign national for asking about or asserting their rights under the EPFNA; requires recruiters and, in some situations, employers to distribute information sheets to foreign nationals setting out their rights under the EPFNA and applicable provisions of the ESA (Ontario Ministry of Labour, n.d.)

4.1.3. THE MARKET-LED CARE MODEL

4.1.3.1. The United Kingdom's older person care system: Private care providers and migrant labour

*Care regime – health care vs older person care.*¹¹⁸ Access to health care is determined by need, not the ability to pay – this is the core principle of the National Health Service (NHS). Hospital-based and community nursing services and nursing care in care homes are free at the point of delivery for all United Kingdom residents and are funded almost entirely by the State out of general taxation. Thus, private sector involvement in the health-care system is limited.

On the other hand, access to long-term care for older people is organized differently. This relies on both unpaid care by family members and others, and on publicly and privately funded social care services. Social care services cover institutional care in residential and nursing homes, and care for people living at home and receiving “home care” services. Access to publicly funded social care is means-tested as well as needs-tested in England, Wales and Northern Ireland; a far greater portion of total costs of long-term care is met by private means. The provision of publicly funded social care is the responsibility of local authorities (although there is often a blurring of the boundaries between health care and social care needs of older people).

In the context of rising costs of older person care and budget constraints, the provision of care for older persons in the United Kingdom has undergone four changes of emphasis. First, there has been a shift in the formal care provision for older people with relatively high levels of dependency (thus in need of intensive support) away from institutions to home-based care. The trend towards home-based care, even by formal service providers, follows the community care reforms in 1993. Second, local authorities have increasingly directed cash-limited budgets to older people with higher dependency and consequently greater needs. Eligibility criteria for publicly funded support have become tighter, leaving those with relatively lighter dependency to look for alternative care services. Third, local authorities have increasingly contracted private and voluntary sector organizations to deliver the majority of home-care services. Finally, beginning in 2000, cash-for-care payments to persons aged 65 and over in need of care further devolved care responsibilities to the care recipients and their families; they were given “freedom of choice” to determine the type of care most suitable to their needs.

The social care workforce mainly consists of two broad types of worker: a “direct care” workforce providing regular support (including care assistants, home carers and support workers); and professional staff (nurses, social workers, occupational therapists and other staff with care-related professional qualifications) who make up a smaller proportion than the former.¹¹⁹ The introduction of cash-for-care schemes has led to the emergence of another group of direct care workers; namely, “personal assistants” employed by people receiving direct payments to buy their own care service on the market. The private for-profit sector is the main employer of social care workers. In 2008/2009, the for-profit sector employed 53 per cent of the total social care workforce, while one-fifth were employed by the public sector (local authorities and NHS) and 18 per cent by the private voluntary sector (Cangiano et al., 2009).¹²⁰

¹¹⁸ The main source for this subsection is Cangiano et al., 2009.

¹¹⁹ In 2006/07, direct care workers made up nearly 70 per cent of the social care workforce. Professional jobs were much fewer in number (90,000 compared to 764,000 direct care workers in 2006/07).

¹²⁰ Figures at the time of the study by Cangiano et al. (2009). They provide various estimates of the size of the United Kingdom's social care workforce, noting deficiencies in data on care workers and their migrant status. Among others, home care workers directly employed by individuals who are not receiving any public support and paying entirely for their home care may have been excluded by certain sources.

Migration regime – from reliance on foreign care professionals to restrictive policy: Historically, the United Kingdom has relied heavily on foreign-born doctors and nurses in staffing the NHS, but much less so with regard to social care. Relaxed entry controls for Commonwealth citizens in the post-war period facilitated the active recruitment of health professionals from the Indian subcontinent and Caribbean. The subsequent work permit system continued to facilitate admission to occupations where shortages were being experienced, including doctors, nurses and related health professions.¹²¹ Work permits could be obtained for “senior care workers”¹²² and for other types of health and social care workers (nurses in nursing care homes) from outside the EU. Following EU enlargement in 2004, Eastern Europeans from the “Accession 8” countries were allowed to work in the United Kingdom, thereby providing a new source of labour, which eventually proved significant for the social care sector. From the late 1980s to the late 1990s, foreign employment in the health and medical sector rose by 47 per cent.

The year 2005/06 saw a reversal in migration policy, alongside the NHS financial crisis, a freeze on overseas recruitment, restrictions on foreign-born or foreign-trained doctors and nurses, and reform of the Overseas Nurses Programme for nurses trained outside the European Economic Area (EEA). The post of “senior care worker” was downgraded to “not skilled” and thus became ineligible for a work permit unless the specific post required higher formal qualifications (NVQ Level 3) and paid a higher hourly rate,¹²³ which were considered too high by many social care sector providers/employers. The post-2008 migration regime consists of a new points-based entry system that reduced the number of entry channels for non-EEA migrants wishing to work in the United Kingdom. It rests on a distinction between skilled and low-skilled jobs, and is increasingly restrictive towards migrants defined as less skilled. Skill is largely measured by prospective earnings, qualifications, training and experience. Social care occupations are categorized as “low-skilled”, so that posts such as care assistants in residential care homes, could no longer be filled by recruitment from outside the EU. Restrictions on the entry of older person care workers under the “Tier 2” visa have remained high, even though the qualification level and hourly wage threshold were reduced.¹²⁴

*Employment regime and migrant care workers:*¹²⁵ Because of much tighter migration restrictions, work-related migration to the United Kingdom is relatively low. An analysis of labour force survey data and a survey undertaken by the Centre on Migration, Policy, and Society (COMPAS) (Cangiano et al., 2009) show that most migrant care workers have entered the United Kingdom through non-labour migration entry channels. The immigration status of migrants working in the social care sector varied widely.¹²⁶ Four in ten migrant carers belonged to categories under immigration control (work permit holders, 19 per cent; spouses, 7 per cent; students, 9 per cent; other visa category, 2 per cent), and thus possibly faced restrictions in access to the labour market. The rest were UK nationals (28 per cent), EU nationals (20 per cent) and migrants with Indefinite Leave to Remain (14 per cent).

¹²¹ Health professionals were allowed to enter on fast track work permits for occupations which were experiencing shortfalls and for doctors through the Highly Skilled Migrants Programme.

¹²² Before 2007, “senior care workers” were eligible for work permits; and the requirement for qualifications at National Qualifications Framework (NQF) Level 3 was applied with some flexibility.

¹²³ At least £7.02 per hour at that time.

¹²⁴ The Tier 2 Visa is a route for skilled workers, who come from outside the European Economic Area and Switzerland and wish to enter the UK for employment. Such workers should have a job offer and a certificate of sponsorship from a UK employer. For details see <https://www.gov.uk/tier-2-general>.

¹²⁵ The term “care workers” here refers to staff who provide care directly, including “senior care workers” and care assistants working in residential and nursing homes; home-care workers employed by home-care agencies; other agency workers; live-in and domestic care workers employed directly by older people or their families. Not included in the term “care workers” are professional staff, such as nurses, social workers and occupational therapists. The focus of the research by Cangiano et al. (2009) is care workers, with special attention to those providing older person care.

¹²⁶ Estimates of the stock of migrant care workers are based on labour force survey and COMPAS survey data.

In principle, migrants who are allowed to work in the country have the same employment rights as other employees, subject to restrictions linked to their immigration status, for example the right to change jobs. Migrants whose employment contracts are not valid because they are not allowed to work under the terms of their visa, are unlikely to be able to claim their rights relating to a job, such as challenging any discrimination encountered. Migrants, like other employees, have fewer rights if they work in private households, most significantly in relation to the National Minimum Wage and Working Time Regulations 1998.

Migration status and working conditions: The COMPAS survey of migrant care workers in the United Kingdom (covering 557 migrant care workers) points to a correlation between the uncertainty of immigration status suffered by skilled workers and inequities in working conditions. Cangiano et al. (2009, p. 184) argue that the “willingness” of migrant workers in the health sector “to accept unattractive working conditions can reflect the constraints related to their immigration status rather than genuine choice”. The work permit of non-EEA nurses and older person care workers ties them to their employer, who is responsible for obtaining and renewing the work permit. Although a non-EEA migrant has the right to change employer, fear of losing an opportunity to renew one’s work permit, or to apply for permanent residency or citizenship, often prohibits a migrant from taking steps to do so. Non-EEA students are generally allowed to work up to 20 hours per week during term time and full time during holidays; and those studying nursing could work more than 20 hours if the job were part of the course. Some care homes reportedly employed social care “students” who effectively worked full time with limited classroom time, a means by which they and the agencies that recruit them could avoid the restrictions on entry to work in the sector. Migrants who enter to marry a UK or EEA citizen are eligible to work in the United Kingdom, and therefore in the care sector, but access could change with the imposition of new requirements (such as the English language test).

Private sector employer and working conditions: With the expansion in the number of private providers, the private sector has become the dominant employer of care workers. First, this implied a deterioration in the average wages of care workers because the private sector pays comparatively lower average wages than the public sector (local authorities and NHS). At the time of the Cangiano et al. study, median wages ranged from £5.80 in private hospitals to £8.00 an hour for jobs with local authorities, with the voluntary sector lying in between (Cangiano et al., 2009, p. 78). Average wage levels were higher in domiciliary care (£6.80) than in residential care (£6.10). Second, this led to the increased presence of foreign-born workers in care jobs, predominantly in lower-paid jobs in private residential and home-care services. Foreign-born care workers became over-represented in the private sector: of those who entered the United Kingdom in 1998, 79 per cent were employed by private sector organizations in 2012 while the corresponding number of UK nationals was only slightly above half (Cangiano et al., 2009). Labour force survey data further show that the proportion of foreign-born care assistants and home carers increased from 8 per cent to 18 per cent between 1998 and 2008, despite an increase in the number of UK-born care workers (Cangiano and Shutes, 2010, cited by Shutes and Chiatti, 2012, p. 397). The reliance on foreign-born workers to provide low-paid care labour in private older person care services in the United Kingdom is reflected in their levels of pay compared to UK-born care workers.¹²⁷ In 2008, 42 per cent of foreign-born care workers who entered the UK in 1998 earned less than £6 per hour gross, and 22 per cent earned £8 or more. By contrast, 31 and 32 per cent of UK-born care workers were in the lower and upper ends, respectively, of the wage spectrum (Cangiano et al., 2009).

Length of residence and migrants’ working conditions: The labour force survey data also show that, among foreign-born care workers, “recent” migrants (within ten years of arrival in the United

¹²⁷ There are differences between private care providers. Those providers that target the more affluent older people, who were privately financing their care, claimed to be less reliant on low-paid workers (Shutes and Chiatti, 2012, p. 397).

Kingdom)¹²⁸ tended to experience the least favourable employment conditions compared to long-established migrants and UK-born care workers. Recent migrants were more strongly represented in the private sector (79 per cent) while this was the case only for just over half of UK-born care workers. While 23 per cent of UK-born care workers were employed by local government authorities (with better pay and working conditions), this was the case for only 5 per cent of recent migrants and 18 per cent of long-established migrants (Cangiano et al., 2009, p. 77). A similar pattern was observed for nurses; migrant nurses who had recently arrived were at greater risk than UK-born and long-term residents of being paid below the national minimum wage. Recent migrants were less frequently found in part-time jobs and were more likely to be enrolled in training activities, assigned to shift work and employed on temporary contracts. On the whole, Cangiano et al. (2009, p. 79) did not see a significant difference between the UK-born workforce and those migrants who have been working in the United Kingdom for a long time. The findings showed that those who stayed long enough in the social care sector moved from the private to the public sector when the opportunity arose. Because resident workers – UK-born and long-established migrant workers – tend to concentrate in those sectors and activities offering better working conditions, i.e. local authorities and the NHS, a larger pool of demand in the less desirable jobs remains unmet.

Migrants, mostly recent migrants, with few choices and employment options, tend to take less desirable jobs. Higher proportions of foreign-born care workers worked long hours (30 per cent working more than 40 hours a week compared to 18 per cent of UK-born workers); and did shift-work (74 per cent of foreign-born versus 60 per cent of UK-born workers). In home-care services, migrant workers were employed in non-permanent, flexible forms of employment, such as “zero-hour contracts” (Shutes and Chiatti, 2012, p. 398). Interviews with employers of migrant care workers confirmed that migrants were preferred because of the difficulty in employing UK-born workers, mainly due to low pay and shift work, and, in contrast, migrants’ willingness to work unsocial hours and their good “work ethic” in spite of the challenging working conditions (Cangiano et al., 2009).

Migrant women: Women constituted the overwhelming majority of the social care workforce – in 2006/07, about 85 per cent, and higher proportions among direct care workers (88 per cent), older person care workers (88 per cent) and registered nurses (89 per cent). But they were less well-represented among senior managers (71 per cent). Although constituting a minority relative to the women, men’s share was larger among full-time jobs than part-time jobs (19 per cent and 9 per cent, respectively), smaller in home care than in other services, and greater in enterprises with fewer than ten employees than in larger-sized enterprises. Some ethnic groups were over-represented – non-white minority ethnic groups accounted for 17 per cent of care workers (both UK-born and foreign-born). Black or Black British workers were over-represented in direct care workers – 10 per cent of all care workers, three times their share in the overall UK workforce. British minority ethnic workers posted a higher proportion of nurses in nursing homes than in other care institutions.

4.1.3.2. The United States: Long-term care and migrant labour

*Older person care regime:*¹²⁹ Much long-term care is provided unpaid by family members, friends and neighbours as most older people live either in their own homes, with or without a spouse, or in the home of a close relative. According to Martin et al. (2009), nearly all (about 95 per cent), of non-institutionalized older persons with long-term care needs received at least some unpaid assistance, but almost 67 per cent relied solely on unpaid assistance, primarily from wives and adult daughters.

¹²⁸ “Recent migrant” is a relative term. For researchers Cangiano et al. (2009), whose study was published in 2009, a “recent migrant” was one who had arrived in the United Kingdom since 1998, i.e. within 10 years of the survey date.

¹²⁹ The main source for this subsection is Martin et al., 2009.

With an increase in disability, older persons tend to receive more and more unpaid care, and in many cases this is complemented with some hours of paid assistance. Some 86 per cent of older persons with three or more limitations in activities of daily living resided with others, receiving 60 weekly hours of unpaid care and a little more than 14 hours of paid assistance. Almost 75 per cent of the primary caregivers were women, 36 per cent were adult children and 40 per cent were spouses.

Alongside unpaid care is a patchwork of public and private programmes and sources of funding, which have evolved over time, that support long-term care provision.¹³⁰ Major public funds come from the Medicare and Medicaid programmes. The federal Medicare programme provides health insurance to almost all persons aged 65 or older. Medicare was legislated primarily to pay for acute and primary care, but it also provides limited coverage of skilled nursing provision and “home health care” services to Medicare enrollees who meet certain requirements. In 2005, it financed 20 per cent of national long-term care expenditure, including 16 per cent of nursing home care and 27 per cent of home health-care costs. The Medicaid programme is a federal/state safety-net health insurance programme created in 1965 to finance care for the poor. There is wide variation in the amount that each state pays to match the federal payment for Medicaid, as well as in the implementation of the programme. In 2004, public funds accounted for approximately 60 per cent of national long-term care spending while out-of-pocket spending – expenditure borne by care recipients and their families – accounted for about one-third. Private long-term care insurance (either employer-based plans or individual policies) financed only about 4 per cent of the older population’s long-term care needs.¹³¹

Long-term care is provided in various settings, depending on the recipient’s needs and preferences, the availability of informal support and the source of reimbursement. First, home care, delivered in private homes, consists of paid and unpaid services, including skilled nursing and assistance with personal care (i.e. home health care) and non-medical, primarily personal, care. Second, residential care, consisting of “assisted living and board and care” facilities, provides care to those who can no longer remain alone in their homes but do not require the assistance of a nursing facility. Various types of congregate living arrangements offer residential care, under state and local jurisdictions. Third, adult day care is for older persons who continue to reside in their own homes but who may go to the centres for care services and leisure activities as well as for the company of others. Fourth, the nursing home facility, which is the primary institutional setting for long-term care, licensed and regulated by the federal government, receives significant Medicare and Medicaid reimbursement.¹³² However, Martin et al. (2009) noted that more and more acute care services, formerly provided in hospitals, were being provided in skilled nursing facilities, and that private homes were increasingly the setting of first recourse.

Among the paid long-term care workforce, the physician is the primary health professional in acute care and often supervises formal care; and nurses (registered nurses and licensed practical nurses) provide the bulk of “skilled” services. However, the vast majority of the paid long-term care workforce are so-called “direct care workers” (e.g. certified nursing assistants, home health or home care aides, personal care workers and attendants) who deliver most of the hands-on, personal care and assistance

¹³⁰ This is unlike childcare which is *not* financed or provided for by the state.

¹³¹ In 2004, 29 per cent of long-term care insurance policies in force were held through employer-based programmes. Although they offer significant advantages over individual insurance policies, in most employer plans it is the policy-holder who pays the entire premium.

¹³² In 2004, 62 per cent of approximately 16,100 nursing homes were for-profit; 31 per cent were non-profit and the remainder were government-sponsored.

with daily life in care facilities (i.e. nursing homes, residential care facilities, home health or home care agencies).¹³³

Less visible – in-home, self-employed care workers: There is a segment of paid care providers who are less visible as they neither work in care establishments nor are employed by them, but are self-employed and provide care services directly to older person care recipients or to their families in their own homes. Martin et al. (2009), who analysed data generated by the American Community Surveys (ACS), noted an increase in self-employed home-care workers, hired directly by private households to provide personal assistance services and other supportive tasks to older people.¹³⁴ The authors attributed the increasing number of self-employed care workers to federal and state support of “consumer-directed” (or “self-directed”, the term used by MEDICAID) models of service delivery, which enable care recipients to hire, direct and fire their own home-care workers. Under federal guidelines, states have various options and, in some states, self-directed schemes also enable care recipients to employ members of their family to provide care.¹³⁵ Another facility that may be helping care recipients and families to directly purchase care services or hire care workers is the Child and Dependent Care Tax Credit (CDCTC), a tax credit that helps working families pay expenses for the care of children, adult dependants or an incapacitated spouse. However, this might have limited use due to caps on expenses, income eligibility thresholds and other requirements regarding the employment status of the claimant and of the caregiver hired.¹³⁶

The study on domestic workers by the National Domestic Workers Alliance (NDWA) draws further attention to this “invisible” group of care workers – nannies, older person caregivers and housecleaners (Burnham and Theodore 2012). Also using ACS data, the report highlights that between 2004 and 2010, the number of nannies, housecleaners, and caregivers working in private households and directly paid by their employers rose from 666,435 to 726,437, an increase of nearly 10 per cent (Burnham and Theodore, 2012, p. 10).¹³⁷ The actual number of domestic workers can be expected

¹³³ To become certified as a nurse aide, federal law requires less than two weeks of training or passing a certification exam; most states add to these requirements. Home health aides must pass a federally mandated competency exam for their employers to receive Medicare reimbursement. Federal continuing education requirements for home health aides and nurse aides are minimal; the content is left to the individual states and providers. The states determine the regulation of other direct care workers, including those who work in assisted living, for home-care agencies or who are independent (self-employed) providers; but they typically receive little or no training (Martin et al., 2009).

¹³⁴ The self-employed care workforce was estimated at 134,000, but this figure was probably an underestimation, according to the authors, because self-employed workers were not captured by databases.

¹³⁵ Sourced from MEDICAID (USA) www.medicaid.gov/medicaid/ltss. Also see “Consumer Directed Personal Assistance Program”, available at www.health.ny.gov/health_care/medicaid/ (revised July 2016) and “Understanding Consumer Direction in Long Term Care”, available at <https://www.payingforseniorcare.com/longtermcare/resources/consumer-direction.html> (updated May 2016).

¹³⁶ For further information, see Tax Credits for Workers and Families, “Child and Dependent Care Tax Credit”. Available at: www.taxcreditsforworkersandfamilies.org/federal-tax-credits/. Families can claim up to \$3,000 in dependant care expenses for one child/dependant and \$6,000 for two children/dependants per year. The credit is worth between 20 per cent and 35 per cent of these expenses, depending on a family’s income. Eligible families with adjusted gross income (AGI) of \$15,000 or less can claim 35 per cent of these expenses for a maximum potential credit of \$2,100. The percentage of expenses that a family can claim steadily decreases as income rises, until families with AGI of \$43,000 or more reach the minimum claim rate of 20 per cent, qualifying for a maximum potential credit of \$1,200. The use of the CDCTC is highly regulated. To qualify for the CDCTC, a parent must be working or in school; for married couples, both adults must be working or attending school. In general, allowable expenses are capped at the earnings of the lower-earning spouse. A CDCTC claimant must include on the tax forms the name and taxpayer identification numbers of the caregivers. If someone is paid to come to a claimant’s home to provide the care, the claimant may be considered a household employer and have to pay employment taxes. The tax credit cannot be claimed if the caregiver is the care recipient’s spouse or child.

¹³⁷ These ACS figures do not take into account workers who are hired through placement agencies or those who work for private cleaning companies. Nor do they include some types of workers who could be considered domestic workers, such as cooks or chauffeurs. Furthermore, overlap and fluidity of categories complicates the way that domestic workers are counted. For example, a caregiver to an older person might perform many of the same functions as a home health aide, and vice versa (Burnham and Theodore, 2012).

to be far higher because undocumented immigrants – who make up a substantial group of domestic workers – tend to be undercounted for various reasons.¹³⁸ While the ACS did not ask non-citizens about their documentation status, the survey confirmed that substantial numbers of domestic workers were undocumented immigrants. Some 95 per cent of nannies, caregivers and housecleaners surveyed by ACS were female. The majority were women from racial and ethnic minority groups: 54 per cent of ACS respondents identified themselves as Latina or Hispanic, black or African American, Asian or Pacific Islander or “some other race”, other than white.

Migration regime: The United States has few dedicated avenues of legal admission that select for professional care workers, and has no effective avenues that target direct care workers (Martin et al., 2009, pp. 12–16; Lowell, 2012, pp. 3–6). Both permanent and temporary classes of admission include some employment-based visas for professionals in health care, but they tend not to favour long-term care workers. Most employment-related immigrant visas are for highly skilled workers and thus apply only to professional health-care providers, such as doctors and nurses (excluding direct care workers who are regarded as lesser skilled). The admission of professional care workers is, in addition, determined by accreditation rules governed by both non-governmental bodies and government policies.¹³⁹ Because legal admissions favour skilled workers with employer sponsorship, most low-skilled immigrants are sponsored through family channels and find employment subsequent to admission; or come into and/or stay and work in the country clandestinely or without following the procedure for legal admission.¹⁴⁰ The temporary work visa for lesser skilled workers (H2-B) is relevant for direct care workers but applications are likely to be rejected because the work is not necessarily temporary in nature. Therefore migrant direct care workers find their way into the United States’ care labour market predominantly through the family reunification or refugee classes of admission, and, to a lesser extent, through “unauthorized” entry (i.e. in violation of immigration rules). It was estimated that, as of 2008, the “unauthorized” migrants comprised 3 per cent of foreign-born professional workers and 21 per cent of foreign-born care workers looking after older persons (Martin et al., 2009, p. 16).

Migrant workers in the US care economy: The United States has long been a major destination of doctors, nurses and other highly educated and skilled migrants (refer to section 2). Martin and Abella (2014) provide some figures. In 2000, half of the foreign-born doctors and nurses in the OECD countries were in the United States, yet it accounted for just one-quarter of residents in OECD countries. In 2010, one-sixth of those employed in health-care occupations in the United States were born outside the country, the same percentage as the 16 per cent share of all US workers who were born outside the United States, but the share of foreign-born workers was higher in particular health-care occupations. For example, 27 per cent of US doctors and surgeons in 2010 were foreign-born, and 22 per cent of those working in health care support jobs, including nursing and home health

¹³⁸ NDWA researchers confirmed that the Census Bureau ACS undercounts undocumented immigrants due to reluctance on the part of many to share information with governmental entities, and because of language barriers and other inadequacies in data collection methods (Burnham and Theodore, 2012, p. 10).

¹³⁹ Physicians who are foreign medical graduates must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG), pass the US Medical Licensing Examination, complete an accredited residency training programme in the United States, which takes three or more years, and apply for a state licence to practise. Other health professionals (e.g. registered nurses, licensed practical nurses, therapists, physician assistants) have to be accredited by the CGFNS International (formerly the Commission on Graduates of Foreign Nursing Schools) (Martin et al., 2009, p. 19).

¹⁴⁰ Unauthorized entry occurs in a number of different ways. About 55 per cent are believed to have entered clandestinely, largely across the land border with Mexico, although others arrive by sea, often in makeshift boats or rafts. About 45 per cent enter through recognized ports of entry. Some do so with fraudulent documents; counterfeit passports, visas and other identity documents may be used. Still others enter having obtained legitimate visas, often as tourists, and then overstay the period that the visa covers. In other cases, the migrants enter as temporary workers but fail to leave when their period of work authorization ends (Martin et al., 2009, p. 16).

aides, were born outside the United States.¹⁴¹ Health-care occupations that had the lowest shares of foreign-born workers in 2010 include registered nurses (10 per cent) and technicians (12 per cent).

ACS data on long-term care workers¹⁴² for the period 2003 to 2006 show that substantial proportions of direct care workers, who made up the bulk of LTC workers, were foreign-born: 24 per cent of personal and home-care aides, and 20 per cent of nursing, psychiatric and home health aides. The share of foreign-born was greatest among care workers employed by private households (27 per cent), establishments providing individual and family services (27 per cent) and those providing home health-care services (23 per cent).

“Unauthorized” migrant workers (those who enter and/or stay in violation of immigration rules) tend to be more successful at finding employment in the less skilled and lower paid direct care workforce, but “they are not disproportionately concentrated in these jobs” (Martin et al., 2009, pp. 23–24). Martin and Abella (2014) also note that “a large but unknown share” of in-home caregivers were foreign-born, including many who were “unauthorized” migrants in the United States. Many of them cared for children and older persons in private homes. According to the ACS (as reported by Burnham and Theodore, 2012), 46 per cent of domestic workers were foreign-born and 35 per cent were non-citizens.

Working conditions in the older person care, long-term care sector: Using the same ACS data set mentioned above, Martin et al. (2009, pp. 31–33) provide substantial information on the working conditions of direct care workers and professional care workers providing long-term care services in private households and in LTC establishments or organizations. Their main conclusion was: working conditions in the whole long-term care sector were largely of poor quality. Jobs in the sector paid less than jobs in other sectors. Direct care workers were in a worse situation: they earned less than the median wage for US workers. They were also less likely to be covered by employment benefits, such as health insurance for themselves and their families.

Comparing immigrant and native-born workers, the ACS data show that the differences between immigrants and non-migrant care workers were not significant and that, on some indicators, immigrants may be slightly better off than native-born workers (Martin et al., 2009, pp. 31–33). Foreign-born workers tended to work slightly longer hours across all LTC jobs, with the exception of practitioners (professional health workers, such as doctors), whose average hours were the same as their native-born counterparts. On average, immigrants worked 40 hours per week while native-born worked 37 hours. Some 78 per cent of immigrant workers worked full-time compared with 72 per cent of native-born workers.

With regard to earnings, foreign-born care workers earned more than native-born, at an average of \$233 per week across all long-term care jobs, as well as more in each individual long-term care occupation. A regression analysis of migrant–native wage differentials, holding constant the number of hours worked, experience, language and educational differences of migrants and natives, showed that foreign-born workers still earned significantly more than natives in all LTC occupations. Martin

¹⁴¹ By region of origin, the highest shares of foreign-born doctors among health-care workers were from Asia, and almost 30 per cent of all health-care workers in the United States in 2010 who were born in Asia were doctors, followed by Africa and OECD countries, with about 25 per cent each. The highest share of less-skilled health-care aides among foreign-born health-care workers came from the Caribbean, at over 50 per cent, followed by almost 40 per cent of health-care workers born in Africa and Latin America (Martin and Abella, 2014).

¹⁴² Martin et al. (2009) identified LTC workers by selecting occupations in specific industry categories, including private households. Direct care workers covered were personal and home-care aides, and nursing, psychiatric and home health aides. Professional care workers covered were licensed nurses, registered nurses, therapists and physician assistants and practitioners. LTC industries covered are: private households as well as establishments or organizations providing individual and family services, home health-care services, residential care without nursing, nursing care facilities, outpatient care centres and hospitals.

et al. (2009) had no clear explanation why the long-term care foreign-born workers earned more than native workers, particularly considering the fact that immigrants in most other sectors most often earned less than natives, after adjusting for experience and skill differentials. A possible explanation they proposed was that the foreign-born care workers tended to have longer tenure with their employer or they worked exceptionally well with older persons. It is not clear from the report whether the analysis disaggregated long-term care workers by occupation or industry, or whether these categories were taken into account in the regression analysis. This may be a weakness in the analysis; it is reasonable to expect that hourly rates of practitioners and professionals in formal establishments would be much higher than those of direct care workers employed by private households. Another possible explanation is that many self-employed and undocumented migrants were not captured by the ACS – a limitation mentioned above. The results of the NDWA survey (see below) of domestic workers point to a different scenario of very low and precarious earnings among care workers employed by private households.

In terms of employment outcomes, foreign-born workers posted slightly lower rates of unemployment, 4.2 per cent; native-born, 4.8 per cent. Foreign-born professional care workers experienced unemployment rates similar to natives, both groups having exceptionally low rates of unemployment. Foreign-born direct care workers had lower rates of unemployment than their native-born counterparts. Foreign-born practitioners were much less likely than natives to be self-employed.

Working conditions of domestic workers: The NDWA national survey generated data on working conditions of domestic workers (Burnham and Theodore, 2012). Their sample was not limited to older person caregivers but included childcare workers and housecleaners.¹⁴³ Nonetheless, their results indicate the employment situation of care workers employed by private households. Substandard working conditions were pervasive; wage rates were low; the work was often hazardous to health and safety; and workers rarely had effective recourse to improve substandard conditions (box 4.5).

Domestic workers are explicitly excluded from the protections of key federal labour and employment laws and standards. For example, the 1935 National Labor Relations Act (NLRA), which guarantees workers' rights to form unions, choose representatives and bargain collectively, does not apply to either agricultural or domestic workers. In the United States, care workers, who are engaged by the Government at state county level to provide home-care services paid for by Medicaid and Medicare, are considered by the Government to be independent contractors (self-employed, not employees) and thus without the right to collective bargaining. In several states, however, home-care workers have struggled to gain the right to organize and bargain with the state government. During the period between early 2010 and October 2013, state-level legal developments either expanded or limited the right of home-based childcare providers to organize and negotiate with the state (Blank et al., 2014).

Federal anti-discrimination law excludes most domestic workers on a de facto basis, because it applies only to enterprises with multiple employees. Similarly, domestic workers are excluded from the protections of the Occupational Safety and Health Act, which does not apply to employers who hire workers to perform household tasks. This absence of institutional employment rights and protections leaves domestic workers particularly susceptible to employer abuse and exploitation.

¹⁴³ The NDWA surveyed 2,086 nannies, caregivers and housecleaners in 14 metropolitan areas of the United States. The survey was conducted in nine languages. Domestic workers from 71 countries were interviewed. The study employed a participatory methodology in which 190 domestic workers and organizers from 34 community organizations collaborated in the survey design, the fielding of the survey and the preliminary analysis of the data.

Box 4.5. Working conditions of domestic workers in the United States: Highlights of the NDWA survey results

The NDWA survey revealed the following facts:

- low pay is a systemic problem in the domestic work industry
- 23 per cent of workers surveyed are paid below the state minimum wage
- 67 per cent of live-in workers are paid below the state minimum wage
- using a conservative measure of income adequacy, 48 per cent of workers are paid an hourly wage in their primary job that is below the level needed to adequately support a family.

Domestic workers rarely receive employment benefits:

- less than 2 per cent receive retirement or pension benefits from their primary employer
- less than 9 per cent work for employers who pay social security contributions
- 65 per cent do not have health insurance and only 4 per cent receive employer-provided insurance.

Domestic workers experience acute financial hardships. Many indicate that their most basic needs go unmet:

- 60 per cent spend more than half of their income on rent or mortgage payments
- 37 per cent of workers paid their rent or mortgage late during the year prior to being interviewed
- 40 per cent paid some of their other essential bills late during the same time period
- 20 per cent report that there were times in the previous month when there was no food to eat in their homes because there was no money to buy any.

Domestic workers have little control over their working conditions:

- employment is usually arranged without the benefit of a formal contract
- key provisions in standard employment agreements are often absent for domestic workers
- 30 per cent of workers who have a written contract or other agreement report that their employers disregarded at least one of the provisions in the 12-month period prior to the interview
- among workers who are fired from a domestic work job, 23 per cent are fired for complaining about working conditions and 18 per cent are fired for protesting against violations of their contract or agreement
- 35 per cent of domestic workers report that they worked long hours without breaks in the 12 months prior to being interviewed
- 25 per cent of live-in workers had responsibilities that prevented them from getting at least five hours of uninterrupted sleep at night during the week prior to the interview.

Domestic work can be hazardous. Workers risk long-term exposure to toxic chemicals and a range of workplace injuries. During the 12-month period prior to the interview, workers reported having experienced the following:

- 38 per cent of workers had suffered from work-related wrist, shoulder, elbow or hip pain
- 31 per cent suffered from other soreness and pain
- 29 per cent of housecleaners suffered from skin irritation and 20 per cent had experienced breathing difficulties
- 36 per cent of nannies contracted an illness while at work
- 29 per cent of caregivers suffered a back injury.

Domestic workers experience disrespect and abuse on the job:

- they often endure verbal, psychological and physical abuse in the course of their job – without any recourse.

Domestic workers, who are unprotected by contracts and laws available to other workers, fear employer retaliation:

- 91 per cent of workers who encountered problems with their working conditions during the 12 months prior to the interview did not complain because they were afraid they would lose their job
- 85 per cent of undocumented immigrants who encountered problems with their working conditions in the previous 12 months did not complain because they feared their immigration status would be used against them.

Source: Burnham and Theodore, 2012, pp. xi–xii.

4.1.4. MIXED CARE MODELS

4.1.4.1. Germany: Statutory social insurance and its “invisible angels”¹⁴⁴

Care regime: The German care system has been built on the principles of a male breadwinner model and strong family obligations. Until the early 2000s, mothers of small children were not expected to work, and childcare facilities for children under 3 years old were traditionally scarce. Facilities for children aged 3 years old and over were meant for pedagogical purposes and took children for half days only, obliging women to work part time. State policies in the 1980s and early 1990s effectively retained mothers and young children at home,¹⁴⁵ and the 1990s saw only a timid expansion of childcare facilities (Morel, 2007, pp. 630–631). The sharp drop in fertility rates and EU policy agenda on gender equality eventually pushed the State to begin developing and funding childcare services, including child day-care and parental leave benefits.

With regard to older person care, the care regime is based on the following premises: that families provide care for older persons; that family members live together (and can therefore provide the care); that a few hours of caregiving would be sufficient (thus not placing a heavy burden on families); that employing a 24-hour caregiver at home is unaffordable; and that placing one’s relative in a nursing home is unacceptable, even if it were affordable (Lutz and Palenga-Möllenbeck, 2011). Based on 2007 official statistics, 70 per cent of all those receiving a cash-for-care allowance from the State used it for care arrangements in their own homes (Lutz and Palenga-Möllenbeck, 2011, p. 355). Older person care was mostly delivered by family members, primarily women, or by a combination of family members and nursing services (and migrant workers).

Older person care system: In 1994, the Government introduced a universal long-term care insurance (LTCI), so care for those who need it over a long period of time is financed by an insurance system, funded from wage and retirement income, as well as employer contributions.¹⁴⁶ Most Germans (90 per cent or 70.3 million people in 2015) are enrolled in the public scheme, while the remainder purchase compulsory coverage through private health insurers, whose policies conform to the same mandatory

¹⁴⁴ This term is making reference to “angels” by Lutz and Palenga-Möllenbeck, 2011.

¹⁴⁵ For example, the parental leave at that time enabled parents (mothers) to take a three-year leave from work to care for their children until the age of 3 years old. A flat rate benefit was paid for the first two years, and a parent on leave could work for up to 19 hours per week without losing the benefit (Morel, 2007, p. 630).

¹⁴⁶ In 2015, employees and employers each contributed 1.175 per cent of income (up to EUR 97); retired persons pay the full amount; childless employees contributed 1.75 per cent. Coverage includes spouses and children (Nadash and Cuellar, 2017, p. 589).

benefits and have similar contribution rates (Nadash and Cuellar, 2017, p. 589).¹⁴⁷ Germany's LTCI is based on the principles of "rehabilitation before caregiving, caregiving at home before institutional care, and short-stay institutional caregiving before full-time institutional care" (Schulz, 2010). Unpaid (family) caregivers therefore play a significant role; they are mainly the care recipient's spouse or partner (28 per cent), daughter or daughter-in-law (32 per cent) and son (10 per cent) (Schulz, 2010, p. 12). As partners are primary caregivers, they tend to be older persons themselves. Germany has therefore also introduced family care leave to induce family members to care for older persons.

The LTCI provides only partial insurance coverage; citizens have to buy additional insurance privately. Programme benefits are flat-rate based, with no adjustments for income or assets; the amount depends on the level of disability, whether care is provided at home or in an institution and whether the beneficiary receives benefits as cash rather than in-kind services (Nadash and Cuellar, 2017, p. 589; Schulz, 2010; Morel, 2007, p. 632). Although benefits are larger for institutionalized care recipients, these do not meet the full cost of care, nor do they cover room and board. Consequently, people living in nursing homes must either pay the difference themselves or, if on a low income, obtain coverage from the German social assistance programme.¹⁴⁸ The German Government has tried to address the funding limitation of the LTCI by subsidizing (at the cost of €5 per month) the purchase by families of supplementary policies with a monthly premium of at least €10, specifically those offered by health insurers (Nadash and Cuellar, 2017). This approach remains consistent with the German tradition of encouraging private supplementation of public programmes.

For home care services, care recipients can choose between cash benefits, in-kind benefits of community care, or a combination of both. The cash benefit paid to the dependent person can be used to remunerate a family member or other similarly informal caregivers¹⁴⁹ (Morel, 2007, p. 632). While compensating a family member for the time devoted to the care of an older family member might seem like a good thing, this approach has gendered implications. Proportionately, many more women than men take up part-time jobs in order to combine unpaid care work and paid jobs in Germany; this cash benefit could further reinforce the expectation that women should devote more time to care tasks within the family.¹⁵⁰

The entry and role of migrant caregivers: Lutz and Palenga-Möllenbeck (2011) argue that insufficient State support for formal care arrangements coupled with uncontrolled direct cash-for-care transfers have led German households to turn to the employment of live-in migrant caregivers in private households. The German care system "tacitly depends on informal work of migrants", while State provision of care allowances uphold the image of family care provision. They maintain that the Government turned a "blind eye to undocumented migrant caregivers", who offer cheap and flexible care labour, while officially combatting undocumented work. A growing share of recipients of informal care engage additional, privately financed "home-helpers" to relieve the burden of a family caregiver. Additional "home-helpers" are mostly engaged for persons living at home who need supervision around the clock due to substantial impairments, a preferred and less costly alternative to institutional care.

¹⁴⁷ Eligibility criteria for the programme target those who, owing to a physical, psychological or mental disease or disability, need significant help in carrying out daily and recurring activities of everyday life over a prolonged period – typically at least six months. Consequently, beneficiaries are, on average, older than the general population: 83 per cent are over the age of 65 and 37 per cent are over the age of 85 (Nadash and Cuellar, 2017, p. 589).

¹⁴⁸ Money allotted by the State for persons needing 24-hour care was far too little to pay for care provided by nursing services, at the time of writing by Lutz and Palenga-Möllenbeck (2011); the ratio was one-third or one-quarter of the funding necessary. Nursing care also involves frequent changes of caregivers, which many older people find unsettling.

¹⁴⁹ Informal caregivers in this sense are family members, friends and neighbours, who provide care without formal contractual arrangements, and not on behalf of a formal institution or organization.

¹⁵⁰ This should be the subject of further investigation.

Lutz and Palenga-Möllenbeck (2011) further observe that home-based care workers are most often women from Eastern and Central European countries. For many years, they were not officially welcome as caregivers and the majority of care migrants were undocumented, most relying on informal social networks. The opening of the German labour market to new EU Member States in 2011 has since made cross-border movement easier.¹⁵¹ Lethbridge (2011) also reports that about 115,000 women migrant workers from Eastern Europe worked in the German care sector as “commuter” migrants, regularly returning to their home countries. They often provide care services which are not covered by the long-term care insurance or are too expensive for care recipients and their families. Some of this work may be undeclared, so no taxes or social insurance are paid. The boundaries between legal and illegal work are often unclear.

At the same time, since 2004, a formal “transnational market” for home-based care services – for self-employed care workers or workers deployed by placement agencies – has emerged in the context of the EU guidelines on service provision (Lutz and Palenga-Möllenbeck, 2011).¹⁵² Agencies placing Eastern European care workers in German families have come to play a key role in the care system. They operate as businesses, free to deliver services in the European Union and across borders.¹⁵³ An increasing number of agencies work to recruit nurses and care workers from Eastern and Central Europe. Some may only arrange a placement but others offer more services, covering the whole process of cross-border recruitment. These agencies are the only point of contact for families who have complaints or problems with the quality of services. Agencies benefit family employers because the workers they deploy are flexible and affordable. For migrant workers, the advantage of agencies may be the fact that they provide “legal contracts”.

It is difficult to obtain precise numbers of migrant care workers, because those in private homes are practically “invisible” and many cross the borders without any form of registration. In 2008, the number of privately financed home-helpers was estimated at 100,000 persons (Schulz, 2010, p. 13).¹⁵⁴ According to estimates cited by Lethbridge (2011), 18 per cent of care workers (in residential and home care) were migrant workers, and many had residence status and contributed to national social insurance funds. Some 74 per cent of these migrant workers were from the EU, with 40 per cent from Eastern and Central European states that had recently entered the EU.

In recent times, there have been indications that German hospitals, clinics and retirement homes are facing labour shortages and are also recruiting more and more foreign care staff, mainly women, from eastern and southern Europe (Knaebel, 2015).

Employment status and working conditions: Interviews by Lutz and Palenga-Möllenbeck (2011, p. 359) with migrant care workers who provide care services to households indicate that the change from an undocumented migrant status to being a “self-employed” caregiver did not necessarily result in an improvement in their working conditions. The care workers spoke of no improvement in income,

¹⁵¹ Until 2011, workers from new accession States required a permit from the German Federal Labour Office. Certain restrictions continued to exist for citizens from Romania and Bulgaria until 2013.

¹⁵² However, there was debate between placement agencies and legal experts regarding whether the service that the former provided conformed to the EU guidelines which promote freedom of service supply. One of the conditions of self-employment is the requirement to work for more than one client, while live-in migrant caregivers work only for one (Lutz and Palenga-Möllenbeck, 2011, p. 356). In one case, a district court in Munich considered a Hungarian live-in migrant care worker’s employment illegal because it did not comply with the German criteria for self-employment: serving only one client; independence from the client’s instructions; and entrepreneurial risk borne by the migrant worker (Lutz and Palenga-Möllenbeck, 2011, p. 356).

¹⁵³ As noted in section 2, in the EU under the Directive 96/71/EC concerning the posting of workers, companies are allowed to post workers to other countries for a maximum of two years. When they are employed, workers are recruited by a company located in their origin country and not in the country where they provide their services; when self-employed, their company is generally not located in the country where services are provided.

¹⁵⁴ It is difficult to determine precise figures due to hidden nature of the home as a workplace.

job opportunities or personal freedom. Instead, they bore more responsibilities and risks – they had to keep up with the legal requirements for self-employment, e.g. by renting an office with other workers to avert suspicion of being an employee; tax and residency law in Germany; social insurance in Poland; and fees for the placement agency.

Care workers employed by a private agency may work without a work permit, and may be moved back to their home country to do care work and replaced by another migrant worker. Home-based caregivers have particularly precarious working conditions (box 4.6).

Box 4.6. From VERDI trade union: Working life of home-based older person caregivers in Germany

Who are they?

- Most usually women, aged between 45 and 60 years.
- Some of them have little chance of finding a job in their own countries, but they often underestimate the difficulty of this type of work.
- Others are already receiving a small pension, but not enough to live on in their home country.

Heavy physical and emotional workload

- The work involves:
- carrying people
- endless hygiene care
- emotional stress.

Extremely low wages

- €1,400 gross on average for full-time attendance on older persons.
- For work of more than 48 hours a week, the wage is well below the minimum wage for the care sector (€9.40 gross in western Germany and €8.65 in eastern Germany); below the general minimum wage in force in Germany since 1 January 2015 (€8.50 gross per hour).

Particularly difficult working conditions

- Working hours are not defined at all.
- Workers often sleep at the place of work.
- They are present seven days a week.
- No right to paid holidays.
- No sick leave.
- Sometimes no sickness insurance.

Barriers to compliance monitoring

- The work involves home care for older persons; there are no official checks for home-based work.
- The sector relies on foreign companies, based in another country.
- No records are held of jobs in which women work as freelancers and undeclared employees.

Source: Steffen M., 2014, cited by Knaebel, 2015.

4.1.4.2. The Netherlands: Redistributing care between the public sector and family

Childcare regime: Dutch society adheres to the male breadwinner ideal and the principle that it is best for children to be looked after exclusively by their own parents. Childcare facilities therefore remained underdeveloped in the 1980s, and began to receive state attention only in the 1990s (van Hooren, 2011, pp. 129–130). Public funds were made available to municipalities for the expansion of childcare facilities. Companies were given subsidies and tax relief to provide childcare to employees. In 2005, a new childcare law shifted subsidies from day-care centres to parents, who could choose what kind of care to purchase for their children – day care or a guest parent who takes care of one or more children in the guest parent’s home or at the children’s home. In 2007, employers’ contributions to the cost of childcare became mandatory, payable through a tax levy. Subsidies for childcare costs also increased. As a result, the number of children in day-care centres, and the number of registered “guest parents” (eligible for the same funding as day-care centres) increased.

At the same time, state policies have supported part-time work to allow parents to combine work and care, as well as to promote employment (Morel, 2007). Dutch legislation enables every employee to tailor their working hours to their requirements and ensures that the rights of part-time workers are properly protected. Partly as a result of this, part-time work in the Netherlands has not, as in some other countries, remained limited to marginal jobs but is also a feature of mainstream employment. Other measures increase work flexibility, such as schemes which allow working parents to save for temporary breaks and various types of care leave. In brief, rather than investing substantially in childcare facilities, the state has given employees responsibility and choice concerning how to arrange their working time in respect of their family life and care roles, regardless of the gendered outcome.

Most women in the Netherlands today continue to work after the birth of their children, and compared with other countries the employment rate of mothers in the Netherlands is high. The participation of Dutch women in the labour market has risen remarkably, from a low 40 per cent in the late 1980s to 71 per cent in 2015, one of the highest rates among EU countries (European Commission, 2016b). In 2014, about 61 per cent of women aged 15 to 64 years old worked less than 30 hours a week on their main job, while only about 20 per cent of their male counterparts did so (OECD, 2016b). Because of their relatively high part-time rates, women’s full-time equivalent employment rate was just 48 per cent while men’s was 75 per cent (European Commission, 2016c).

*Older person care regime:*¹⁵⁵ The provision of older person care services has long been extensive in the Netherlands. State provision of long-term care (LTC) services is among the most generous, inclusive and expensive in the world. The General Law on Exceptional Medical Costs (AWBZ in Dutch) of 1968 funded good quality LTC services. However, in the past three decades, LTC funding and provision have been under budgetary pressures, and support is shifting from institutional care to domiciliary care. Several interventions have been introduced since the 1990s to try to contain LTC costs and shift older person care from the care institutions to the family. These include restricting access to residential care homes, excluding lighter forms of home-care support from AWBZ funding and decentralizing the provision of household help for older persons to municipalities. The *Wet Maatschappelijke Ondersteuning* law (WMO) adopted in 2007, regulates the provision of support and household care for disabled, dependants and older persons, and transferred from the State to the municipalities the responsibility for providing household care and support, whether in kind or in cash, through the use of personal budgets – *persoonsgebonden budget* (PGB). The PGB, introduced on an experimental basis in 1991 and on a national scale in 1995, entitles dependent persons to a “personal budget” to be used for the purchase of care services, whether from relatives or a professional care worker. This policy is based on the principle of giving care recipients greater freedom to decide how best to address their

¹⁵⁵ This subsection draws mainly from Da Roit and van Bochove, 2017, pp. 80–81.

care needs, but it also effectively shifts greater responsibility onto families to manage their care costs. Beneficiaries need to justify their expenses, which supposedly strongly discourages recourse to the low-paid, unregulated workforce (unlike the case of Italy's cash-for-care allowance).

As of 2015, the AWBZ has undergone major reform to save costs while keeping people self-sufficient as far as possible: a shift from residential to non-residential care, decentralization of social care and home help to municipalities, private insurers made responsible for home nursing, and expenditure cuts (Maarse and Jeurissen, 2016; van Ginneken and Kroneman, 2015).

Migration regime: The Dutch immigration policy has not encouraged the inflow of migrant workers (van Hooren, 2011). In general, migrant workers employed in social care came to the Netherlands either through family reunification or as asylum seekers.¹⁵⁶ The employment of nationals from new EU Member States has been the subject of restrictions but, in 2007, the Dutch labour market opened to A8 citizens.¹⁵⁷ Employment of non-EEA/EU nationals in domestic work or home-based care work is practically impossible under the work permit system. The demand for migrant workers (mainly in cleaning) means that migrants work in an irregular situation. Interviews conducted by van Hooren (2011, p. 145) note that migrant domestic workers usually enter the Netherlands legally, on temporary tourist visas, as au pairs, as students or as asylum seekers; they then overstay their permits.

The rise of "Alpha workers", carrying out domestic work: Using their personal budget (PGB), older and disabled persons can hire and pay "Alpha workers" (*alphahulpen*) to perform household care for a maximum of three days per week.¹⁵⁸ Subject to the Dutch law on domestic work or "services at home" of 2007 (*Regeling Dienstverlening aan huis*), employers of Alpha workers are exempt from paying social security contributions and taxes, seeking authorization for dismissal of worker or administrative obligations.¹⁵⁹ It is the worker's responsibility to pay social security and declare taxes (domestic workers are not automatically included in the social security system). Alpha workers do not participate in pension funds, unemployment benefits and insurance covering unfitnes to work, which are part of standard employment contracts. They are entitled to a wage not lower than the national minimum wage, a maximum of six weeks of sick leave (whereas the norm in the Netherlands is two years), 8 per cent holiday payment and four weeks of paid leave.

Since the beginning of 2010, voucher systems were being trialled under the name of "Alfacheques" in several municipalities, such as Breda, Gorinchem, Oisterwijk and Tilburg. Instead of providing care in kind, municipalities distribute these vouchers to persons entitled to WMO benefits, which makes it easier for older beneficiaries to hire and obtain the services of Alpha workers and reduces the administrative burden of payment (EFSI, 2013, p. 27).¹⁶⁰ One voucher can be exchanged for one hour of domestic work; the amount already includes the holiday payment and the paid leave. There are advantages: employers of an Alpha worker have control over the use of "personal budgets" (i.e.

¹⁵⁶ The Netherlands had (like a few other developed countries), in the 1990s, recruited substantial numbers of skilled nurses from developing countries – Indonesia, the Philippines, Poland and South Africa – to meet severe labour shortages in the health-care sector (van Hooren, 2011, p. 141).

¹⁵⁷ The A8 countries are Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.

¹⁵⁸ Compliance with this scheme leads to administrative procedures and, as older persons were often unaware of the obligations associated with being an employer, the Alpha workers scheme is now only considered appropriate for people who are able to take on the role of employer (EFSI, 2013, p. 27).

¹⁵⁹ The law excludes employers of domestic workers from the duty to pay social security contributions and taxes if the domestic worker is employed for only three days a week or less (Basten, 2015, p. 25).

¹⁶⁰ Depending on the personal situation of the beneficiary, the municipality determines the number of hours and vouchers that the beneficiary is entitled to; and the "personal budget" is transferred directly to the beneficiary's bank account. With "Alfacheques", beneficiaries can receive services from an Alpha worker of their choice (EFSI, 2013, p. 27). Municipalities gain too; for example, for a voucher worth E12.80, they can gain E5 to E6 per hour instead of services in kind as alpha workers' are exempted from any social security contributions.

vouchers can only be used to pay for Alpha workers) and do not have to pay any social contribution; and municipalities gain a certain amount per hour. However, the system has also created (or legitimized) a second-rate, cheap form of employment, through which workers who probably have little choice – because of their gender, economic class, ethnicity and migrant status – are subsidizing the Dutch older person care regime.¹⁶¹

Migrant workers in childcare and older person care: As of 2011, van Hooren (2011, pp. 136–139) observed that there was no quantitative evidence that migrants were important private childcare or older person care workers, or that many migrants in an irregular situation were employed informally by care providers. Household survey data show that barely 0.1 per cent of respondents reported hiring a private care worker in the period 1987–2003. However, some qualitative reports indicate that Dutch parents sometimes hired au pairs or undocumented migrants to care for their children. According to the Dupersonth Au Pair Organization, au pairs were “becoming popular”; whereas au pairs came from Eastern Europe before 2004, after that date they came increasingly from Latin America, South-East Asia and Southern Africa (van Hooren, 2011, p. 138). The fact that care work in the private domain is not easy to detect makes the situation difficult to assess accurately.

Da Roit and van Bochove (2017) have observed that a small live-in migrant care market is emerging in the Netherlands and argue that these live-in migrants are likely to be documented because the use of “personal budgets” is closely regulated. Users of live-in migrant care workers are typically older persons with Alzheimer’s disease or Parkinson’s disease who need 24-hour assistance, or at least supervision, and, to a lesser extent, adults with disabilities, such as multiple sclerosis. For persons with heavy care needs, employing a live-in migrant carer is seen as a cheaper alternative to moving into a nursing home, an option which is losing its popularity, and as a better option than purchasing home-care services from home-care agencies, which cannot respond to unpredictable problems and could be quite expensive.¹⁶² The PGB is generous and allows care recipients who are not well-off to pay for the care workers they need. Paying with one’s PGB prevents care recipients from hiring unregulated, informal care workers or undocumented migrants.

Based on field interviews carried out by Da Roit and van Bochove (2017), the most common employment model of live-in migrant care work in the country is one where employment is organized and mediated by Dutch agencies, not direct employment of migrant care workers by private households.¹⁶³ They found occasional, anecdotal stories of live-in migrant workers employed in less formal, direct employment arrangements with private households but had insufficient data to definitively confirm the extent of this practice.

Agencies recruit live-in migrant workers only from EU Member States. “Pendular migration”, where the migrant worker periodically returns to her or his home country, is encouraged. Various contracting models exist. In one model, the care worker’s salary is paid by the home-country organization (the

¹⁶¹ The Alpha worker system is among many measures being implemented in the EU to develop the personal and household services sector, which is seen as having great potential to generate formal jobs for the long-term unemployed and to formalize undeclared jobs in the sector by reducing the cost and simplifying the administrative burden of hiring workers formally, while meeting needs of private households (ILO, 2016a; EFSI, 2013). Examples of other schemes are Austria’s voucher scheme, Germany’s Mini Jobs scheme and Italy’s *Bounti Lavoro occasionale accessorio*. In Germany, employment in household services is classed among those sectors that are characterized by a high degree of precarious work. Workers employed under Austria’s voucher scheme had short-term employment and minimal social security coverage, excluding unemployment, sickness and pension benefits. The unions in Austria have criticized this scheme and have described it as a second-rate employment relationship without sufficient protective provisions, affecting mainly women who represent the overwhelming majority of workers in this labour market segment. See ILO (2016a) for more information.

¹⁶² Round-the-clock home-care services, not on a live-in basis, are offered by some private organizations that work with independent contractors or freelancers, who are not migrant workers but Dutch or other resident professionals.

¹⁶³ Based on interviews by Da Roit and van Bochove (2017) with three researchers and two key actors in the social care sector, and a large organization representing beneficiaries of PGB care allowance.

agency in the migrant's home country). Clients either pay their fees directly to these home-country agencies, which then pay the Dutch agencies and the care workers; or the clients pay the Dutch agency, which transfers part of the money to the home-country agency. These migrant workers are referred to as "posted workers".¹⁶⁴ Another arrangement involves the care worker being on the Dutch agency's payroll. They work according to a schedule that restricts the maximum number of working hours per week. When clients need round-the-clock assistance, two care workers working on shifts are engaged. The legislated labour standards are applied, i.e. the minimum wage law and payment of social security contribution. Nonetheless, it is possible to find migrants who will accept lower salaries in view of the fact that wages in their home countries are much lower. The incidence of payment of subminimum wages has not been determined.

Van Walsum (2011) also notes the scarcity of data on migrants, especially on undocumented migrants, in domestic work. However, she argues, based on available studies at that time, that "the supply side of the *non-subsidized* and *largely undeclared* market in household services, particularly in the larger Dutch cities, has come to consist almost exclusively of migrant workers, many but not all of them undocumented" (2011, p. 148). Many migrants in the Netherlands, particularly first generation migrants, experience difficulty in finding work suited to their qualifications because of language barriers, unrecognized foreign diplomas and, not least, racism. Statistics showed that migrants were over-represented in temporary, casual and low-paid jobs. Providing undeclared services to private households could be a relatively attractive option due to the lack of state control over private homes, ready provision of accommodation and the opportunity to build a social network through the employer and family. Not all migrants are similarly positioned in the labour market, even in respect of undeclared jobs. Van Walsum (2011) observes a stratification in the domestic work labour market along lines of sex, migrant status (documented or undocumented) and race (e.g. Ghanaians versus Filipinos), with respect to ease of finding a job, accessing accommodation and securing better wages and hours.

4.1.5. EMERGING PATTERNS FROM THE COUNTRY CASES

4.1.5.1. Care regime and care demand

Care regimes of welfare states are undergoing restructuring. First, the role of the market and private sector in delivering care (not necessarily funding) has expanded, including in contexts where the public sector has traditionally played the dominant role, via two routes: (a) cash-for-care transfers that allow care recipients to purchase care services or hire care workers directly on the market (Italy, Germany, the Netherlands and the United Kingdom); and (b) public agencies contracting out the delivery of services to private for-profit and non-profit agencies (e.g. Canada, the Netherlands and the United Kingdom). So, although the financial support comes from the state, people find their care services and providers in the private market. Second, where older person care would previously have been delivered in institutions (e.g. hospitals, nursing care homes, homes for older persons), care delivery is being de-institutionalized and re-familialized. Care within the private home setting is being encouraged and made possible by a range of policy reforms and instruments, including limiting care needs that are addressed by publicly funded institutional care, giving allowances or tax benefits to family members who provide unpaid care, cash allowances to allow care recipients to hire paid in-home caregivers, expanding home-care services, foreign caregiver migration programmes and job

¹⁶⁴ Note that posted workers constitute one type of temporary labour migration in the EU, as described in OECD Migration Reports, see OECD (2015). They are defined as "employed in one EU Member State but sent by their employer on a temporary basis to carry out work in another state". Recent EU statements have noted the potential problem involved when posted workers are paid the salary rates of their home country rather than the salary rates applicable in the country where they work.

creation schemes for personal care and household services (e.g. Canada, Germany, the Netherlands and Sweden). Preferences among older persons for “ageing in place”, high costs of hospital and residential care, and declining public budgets for subsidized and expanded institutional care underlie this trend. Associated with de-institutionalization is the devolution of greater responsibilities for care delivery from national governments to local authorities.

Home-based personal care for dependent persons (older persons, children, chronically ill, persons with disabilities) has become an important part of health-care systems. Highly labour-intensive, it may be an area where the pressures of cost-cutting and cost-containment are most felt keenly with regard to care workers’ wages and working conditions.

Cash-for-care allowances (“*indennita di accompagnamento*” in Italy, personal budget or direct payments in the United Kingdom and PGB in the Netherlands) transfer to care recipients and their families the “freedom” (and therefore the responsibility) to choose and arrange their own care provision, including purchasing the care services or hiring the care worker they need.¹⁶⁵ This policy instrument raises a number of employment issues.

First, the category of paid care workers who work for or in private households of care beneficiaries, whether employed directly by them or employed and deployed by private agencies, has grown tremendously. However, employment relationships and working conditions in the private household sector are not always regulated by labour laws or, if they are, provisions are generally inferior to those applicable to other employees (e.g. in the Netherlands, the United Kingdom and the United States). Parallel public policies that promote personal and household care jobs through reduced labour entitlements (e.g. “mini jobs” in Germany, “Alpha workers” in the Netherlands) are likewise stimulating the employment of domestic workers by private households.

Second, care recipients may not be ready to comply with the legal obligations of an employer and formal care workers might easily slide into informality. Measures such as the use of vouchers and simplification of procedures in some EU countries may attenuate this problem (ILO, 2016a).

Third, tensions in an employment relationship between care recipient and caregiver may have negative consequences on the care relationship and quality of care. Barely adequate allowances, public funding cuts and care beneficiaries’ own vulnerability may be pitting care quality against fair terms of employment. Trade unions have expressed concerns that direct payments in the context of local funding shortages has led to potential exploitation of vulnerable migrant workers (Cangiano et al., 2009).¹⁶⁶

Finally, unregulated or poorly regulated use of cash transfers (i.e. beneficiaries being free to use the allowance at their discretion without the need to justify the expense), together with low levels of public care expenditure can encourage the employment of workers under informal contractual arrangements or of migrant workers in irregular situations (such as in the case of Italy).

Older person care goes beyond medical or health care. With rapidly ageing populations and longer life expectancies, the greater need is for “long-term care”, i.e. care of adults who are at risk of having progressive and/or chronic conditions, and who require services to meet their long-term functional needs. This requires a range of medical and non-medical care services. The bulk of the work – the “heavy lifting” – falls on front-line care workers, who provide hands-on care for daily health, assistance for daily living as well as emotional support and companionship, at home, in day-care

¹⁶⁵ Forms of cash provision or tax credit also exist in Finland, France and Spain to assist with childcare and older person care.

¹⁶⁶ A survey by UNISON in the United Kingdom of personal assistants employed under personal budget arrangements found that workers had concerns relating to pay, sick pay, split shift work, lack of pension benefits and casualization of contractual arrangements (Cangiano et al., 2009, p. 15).

centres and in nursing care institutions. This segment of the care workforce is expanding fast in high-income countries with ageing populations, and these workers tend to have less favourable working conditions than other care providers.

4.1.5.2. Migration regime

Migration policies and admission controls of developed countries are increasingly restrictive towards workers in low-wage jobs, and provide limited labour-specific channels for the entry of care and would-be care workers. In Canada, Sweden, the United Kingdom and the United States, most foreign-born care workers were found to have entered the country through non-employment routes, such as family unification, refugee protection and asylum, student, tourist and working holiday visas. Restrictive migration rules tend to channel migrants into jobs with low entry barriers (low or no skills and educational qualifications, little state regulation, informal employment arrangements), into less desirable care jobs that native-born workers do not want or into undeclared work. Most of these jobs are in labour-intensive, home-based care.

Less-skilled/low-wage migrant workers tend to be subjected to a double-standard treatment in comparison to highly skilled, high-income migrants, in terms of unequal rights to mobility and protection in the labour market, family unification, permanent residency and social integration in the host country. The discriminatory treatment can be quite stark (such as in the example of Singapore).

Migrant workers tend to stay in their job in spite of poor, exploitative or abusive working conditions when their migrant status is uncertain or in an irregular situation, when their legal migrant status is tied to a single employer and when the right to future permanent residency depends on continuing employment.

4.1.5.3. Migrant care labour and working conditions

There appears to be a “convergence” in the demand for migrant care workers. They are employed across different care regimes, from familialist care regimes to public services and market-led regimes, and in different institutional contexts, from private households to private residential care homes and private home-care agencies. Migrant workers, overwhelmingly women, along with minority ethnic groups, have become the “backbone” of older person and long-term care services, and of home-based care services.

Foreign domestic workers tend to be significant in the following situations: (i) familial-based care regimes where public care services are scarce and private institutional care is relatively expensive; (ii) where women’s participation in paid employment has become the social norm or an economic policy target; (iii) where affluent populations have the economic power to outsource the burden of unpaid family care to another population group of lesser economic means; (iv) where care-specific foreign worker programmes facilitate their recruitment and employment by private households; (v) where public policies provide incentives and subsidies to encourage private individuals to hire domestic workers; and/or (vi) where employment relationships and working conditions in private households are, de jure or de facto, poorly or completely unregulated.

Migrant workers providing older person care and childcare and home-based care are overwhelmingly women. Migrant men have also found employment in older person care and home-based care services, and in some places (e.g. GCC), comprise substantial shares of the care workforce. Client preferences may be determining the growing demand for male care workers. Another reason for this increase in demand is that, where regular migration channels are limited, home-based care work or domestic work may be the only regular entry points into the foreign labour market (e.g. the share of male domestic workers increased under Italy’s regularization campaigns).

By being disproportionately concentrated in the long-term care segment of the care economy, where pay and working conditions tend to be worse compared to the rest of the health-care economy, migrant care workers are more likely than their native-born counterparts to suffer from poor working conditions. Foreign-born care workers often speak about shorter contracts, more irregular hours, broken shifts and lower pay, in lower level (lower graded or classified) posts, and being allocated more difficult or less desirable care recipients than native-born workers. Care agencies and organizations have faced great difficulties in recruiting and retaining enough native-born care workers to staff the long-term care of ageing populations for many reasons; among them, if not principally, relatively low wages, heavy workload, shift work and irregular hours.

4.2. WORKING CONDITIONS OF CARE WORKERS: A ROUND-UP OF ISSUES

4.2.1. PRECARIOUS MIGRANT STATUS LEADS TO PRECARIOUS EMPLOYMENT

Drawing from country studies of older person and long-term care workers in the United Kingdom (Cangiano et al., 2009), the United States (Martin et al., 2009), Canada (Bourgeault et al., 2009) and Ireland, Spencer et al. (2010) note that experiences of poor terms and conditions were reported in particular by caregivers whose immigration and/or employment status was in an irregular situation. This point was particularly highlighted in the preceding subsections on Canada, the United Kingdom and the United States. Migrant workers with precarious migrant status included those who overstayed their student visas and those who were employed irregularly by older persons or their families (who did not fulfil the responsibilities for employer tax/insurance contributions) to provide live-in care. In these cases, fear about the irregularity of migration status prevented migrant caregivers from voicing complaints about their working conditions. Poor terms and conditions were also reported by those who were employed directly by older persons or their families. The isolation from organizational sources of support and lack of information on employment rights for those employed, and the absence of regulation of direct employment of migrant workers by older persons and their families, may have also contributed to experiences of poor working conditions.

Another example is Australia, where workers on temporary visas have suffered unequal rights and working conditions compared to permanent residents (Pillinger, 2012). Being tied to an employer often leads migrant health and social care workers to tolerate lower pay, longer working hours, poorer working conditions, limitations on applying for promotional positions and career development, and insecurity at work because they fear the consequences of complaining. Respondents on student visas that limit work to 20 hours per week experienced financial hardship. Temporary visa holders had unequal access to health-care and other public services and had to pay for private health-care insurance. In addition, the immigration system was difficult to navigate and beset with delays.

Temporary foreign worker schemes that limit migrants' mobility in the labour market and in society, as well as excluding them from legal and social protection while apparently tolerating their presence in precarious situations (e.g. the foreign domestic worker programmes of Singapore and GCC countries), compel migrant domestic workers to remain low paid, vulnerable and tolerant of poor working conditions. At the same time, the government of their home countries continues to implement policies and programmes that encourage and facilitate their deployment to host countries.¹⁶⁷

¹⁶⁷ For example, in August 2017, the Philippine Government revised rules to allow foreign placement agencies and employers multiple accreditations with Philippine private recruitment agencies and thus increase deployment of Filipino migrant workers overseas. For agencies recruiting domestic workers, the more workers are deployed, the more accreditations would be granted (Jaymalin, 2017). Most Filipino domestic workers go to the Middle East and Asia where legal labour protection is non-existent. The objective of boosting numerical deployment has superseded labour protection.

4.2.2. OLDER PERSON CARE AND THE LONG-TERM CARE SECTOR: GENERALLY POOR WORKING CONDITIONS

In general, long-term care workers receive low wages, work in less favourable working conditions and have less social security compared to other care workers (ILO, 2017b). For example, in Australia, the United Kingdom and the United States, they earned around half (55–57 per cent) of the average earnings of all occupations in 2014 (ILO, 2017b, p. 25, citing ITUC, 2016). A respondent of the Bourgeault et al. study of Canada (2009) summed up the state of working conditions in the long-term sector in Canada: “typically poor across Canada, no matter what model of service organization and delivery”. According to a study of Australia, the worst working conditions and lowest wages in health care are in the older person care sector (Pillinger, 2012, p. 14). The sector employs a high proportion of migrant nursing staff, often on temporary contracts, and a high proportion of international students working part-time.

Being very labour-intensive, older person care is easily adversely affected by cutbacks in public spending and care provision. In the United Kingdom, low wages for care workers have been attributed to the low fees paid to local authorities to provide social care services (Cangiano et al., 2009). Social care is one of the lowest paid sectors of the labour market. It is characterized by shift work and a lack of career opportunities. In Canada, measures adopted by care agencies to contain rising costs include restricting the number of hours of care and the number of visits or services, changing eligibility criteria and training family members to provide some care. As a result, Bourgeault et al. (2009) found many workers employed on a part-time or casual basis, paid by the number of hours worked or per visit, and with no guarantee of being assigned hours. There were workers who were assigned fewer shifts and others who reported a high frequency of night shifts and on-call work.

4.2.3. MIGRANT HEALTH-CARE WORKERS: UNEQUAL TREATMENT AND DISCRIMINATION?

The analysis of OECD labour force data on immigrant health professionals of selected European countries in 2005 by the OECD (2007b, pp. 198–199) shows that differences vary according to which employment indicator is used. For the period analysed, immigrant health professionals worked longer hours and on less favourable schedules than their native-born counterparts. This situation was especially stark among nurses – 13.6 per cent of foreign-born nurses worked more than 40 hours compared to 7.7 per cent of native-born nurses. About 40 per cent of foreign-born nurses and doctors reported working regularly at night compared to 26 per cent among their native-born counterparts; and 47 per cent usually worked on Sundays as opposed to 35 per cent of native-born nurses and doctors. However, in respect of having a permanent contract, there was hardly any difference between the two categories (90–91 per cent had a permanent contract). However, the OECD study did not disaggregate the data by care services component or care occupation, and could not provide any explanation for these trends.

A study of older person care workers in the United States (Martin et al., 2009) found that migrants fared poorly in terms of working hours but were on a similar footing with regard to employment outcomes and fared slightly better on earnings. The survey by COMPAS (Cangiano et al., 2009, p. 81) of the United Kingdom showed a similar pattern in working hours: over 30 per cent of foreign-born care workers (not only health professionals but also caregivers) worked more than 40 hours a week compared to only 18 per cent of UK-born care workers; the comparative figures for shift work were 74 per cent and 60 per cent, respectively. The interviews with migrant care workers in these countries point to a trend: migrant care workers, more often than their native counterparts, are relied upon to work overtime, to work long hours and to accept less favourable shifts. During interviews, employers of migrant older person care workers in these countries expressed a preference for migrant workers because they are “willing” to work all shifts, and maintain a “good work ethic” in spite of a heavy workload.

Calenda's (2014) findings from a survey of Filipino and Indian nurses¹⁶⁸ employed by the NHS or private health facilities, and from the Royal College of Nursing Employment Survey 2013, indicate that there were no major differences between international registered nurses (IRNs) and non-international RNs with respect to working conditions. However, in terms of job security, professional identity and recognition, the differences were evident. Concerns about losing their job were common among IRNs and many felt that working conditions were increasingly unsafe. Most of interviewees had arrived in the United Kingdom before 2006 as a result of the NHS expansion, and have therefore seen cuts in NHS funding, structural reforms of the public health sector and major changes in the United Kingdom's immigration policies. The evidence suggests that the easiest way for an employer to deal with the funding cuts in the public health sector is to reduce personnel and intensify work shifts and workloads. IRNs seem to be in a more vulnerable position with regard to such pressure than non-international RNs. Results also indicate that worsening of working conditions (since the global economic crisis and resultant budget pressures) and experiences of ethnic discrimination and unequal treatment in the workplace are correlated. A substantial proportion of interviewees reported the lack of professional and career prospects, inadequate recognition and valuation by their manager of their professional identity, and a lack of cooperation and solidarity from colleagues in the team. This was corroborated by sentiments regarding unequal treatment and discrimination on ethnic grounds in the workplace.

Racial and ethnic stereotypes and discrimination against migrant care workers in the older person care sector are evident in the experiences and perceptions of care recipients, employers of care workers, and migrant caregivers themselves, as highlighted by various empirical studies (Calenda, 2014 on foreign-born nurses in the United Kingdom; Lutz and Palenga-Möllnbeck, 2011 on migrant workers in Germany; Gallotti and Mertens, 2013 on migrant domestic workers in Belgium, Italy and Spain; Castagnone et al., 2013 on domestic workers in Italy; van Walsum, 2011 on domestic workers in the Netherlands; and Cranford, 2014 on migrant care workers in Toronto and Los Angeles). Migrant care workers often reported discrimination on the part of employers regarding the scheduling of hours of work, allocating responsibilities for different tasks and for more difficult patients, pay rates and overtime compensation. Caregivers also referred to experiences of verbal abuse from care recipients or native born co-workers. Care workers of specific nationalities are preferred by care recipients or not, depending on their perceived characteristics (e.g. Filipinas as most patient, Indonesians as most hardworking, etc.). Some employers suggested preferences among native-born employees for working with other native-born workers. Some clients also expressed ethnic and racial prejudice towards foreign-born workers.

4.2.4. PAY INEQUALITIES, GENDER AND STRATIFICATION OF THE CARE ECONOMY

The literature and studies reviewed for this report hint at important stratification within the care economy and among migrant care workers – not only by gender, but also by ethnicity and race, migrant status, length of residency in the host country, specific care occupation, care service, institutional domain or location of care provision (i.e. home, public or private institution), and whether one has contract or not.

The empirical analysis carried out by England et al., (2002) shows that care work in the United States carried a wage penalty. Workers generally experienced a decline in wages when entering a care occupation and an increase when leaving care work, controlling for changes in measured characteristics of individuals and jobs. The analyses of South Africa's and the Philippines' labour force survey data (Budlender, 2011; ILO, n.d.) point to a wage penalty on domestic work.

¹⁶⁸ The sample consisted of 339 nurses who immigrated directly into the United Kingdom between the 1990s and 2000s.

In the Arab region, wage rates paid to migrant domestic workers are the outcome of negotiations between governments of destination and origin countries, and thus reflect their relative bargaining positions and the relative position of one source country versus another. This political process results in wage inequalities between domestic workers of different nationalities and effectively pits origin countries eager to deploy many of their nationals against each other.

The very few empirical studies that have examined the wages of migrant care workers (nurses and older person care workers) indicate average pay differences between migrant and native-born care workers, between workers in public care providers and those in private care providers, between recent and long-term resident migrants, and between long-term care or social care workers and other occupations (refer to the previous discussions on older person care workers in Italy, the United Kingdom and the United States). However, none of these studies analysed gender-based pay differentials among migrant care workers, for example between female and male migrant care workers, and between female (or male) migrant care workers and female (or male) native-born care workers. Empirical analysis of pay differentials and the issue of a wage penalty on care workers is sorely lacking. The absence of much of this data may be traced to the lack of national data sets that identify international migrants and their occupation and migrant status.

4.2.5. ACCESS TO ONE'S PROFESSION: SKILLS RECOGNITION AND CERTIFICATION

Access to opportunities to practise one's profession should not be overlooked when investigating the working conditions of care workers. For licensed professions, this is an additional barrier to overcome, on top of migration requirements. Several scholars have observed that tougher immigration and professional registration rules for migrant health workers have contributed to generating a climate of uncertainty that is likely to impact on the working conditions of nurses, and their motivations and professional/employment and migration decisions (Calenda, 2014, p. 2).

In the United Kingdom, the costs of accessing the profession have gradually increased since the introduction of tougher migration regulations. Non-EU trained nurses wishing to practise in the United Kingdom as registered nurses are required to undertake, on top of the tests of competence required for registration with the Nursing and Midwifery Council, the Overseas Nursing Programme (ONP),¹⁶⁹ which assesses one's ability to practise in the UK health-care environment, and consists of protected learning time plus, where appropriate, a period of supervised practice (Calenda 2014). Many applicants, even when successful in the initial phase of application, could get stuck in the pipeline. Some employers are able to offer migrant nurses the post of ATA (auxiliary trained abroad) or HCA (health-care assistant) pending completion of the process. In 2005, it was estimated that, at one point, there were 35,000 non-EU trained nurses already in the United Kingdom but who could not start work because they could not find ONP practice placements (Calenda, 2014, p. 9). Shutes and Chiatti (2012) also provide evidence of some migrant care workers with nursing backgrounds but who worked as care assistants, i.e. skilled labour at lower pay, because they could not obtain professional registration.

In Australia, around one-third of migrant health and social care workers covered by a PSI study were working at a lower skill level than they had in their country of origin (Pillinger, 2012). Workers were often placed on an entry level salary scale, despite having many years of work experience. Qualified nurses and midwives were working as "assistants in nursing" because their qualifications were not recognized.

¹⁶⁹ For further information see www.nmc.org.uk.

In some countries, meeting high national language proficiency requirements is a barrier to practising the profession. For example, Bulgarian nurses wishing to practise their profession in Germany have to prove an adequate knowledge of German. The future employer may cover the cost of German lessons, estimated at €1,800 per person for three months, which the worker reimburses over the course of a year (Knaebel, 2015). The alternative is to work as trainee until one passes the language test, or as care assistants for 20 per cent less than the hourly wage of a registered nurse.

Under the Economic Partnership Agreement (EPA) between Japan and Indonesia, the Philippines and Viet Nam, Japan will admit trained foreign older person care workers at a maximum of 1,000 per year per country. However, the requirements to qualify to work as care workers are stringent. Applicants are required to take language lessons for six months and receive on-the-job training before taking national licence examinations within four years of arrival. Since 2008, Japan has accepted 3,800 trainee nurses and caregivers from the three countries (Kyodo News, 2017). In 2015, the pass rate among candidate nurses was 11 per cent and 51 per cent among caregiver candidates.

4.2.6. RECRUITMENT AND WORKING CONDITIONS

Based on the country studies reviewed for this report, it is apparent that migrant care workers enter host countries through the mediation of formal recruitment agencies as well as through informal, social networks. The recruitment process can be quite complex and may involve large numbers of individual and informal intermediaries or labour brokers. Further research on the connections between governance of the recruitment process and specific practices, and the employment pathways and working conditions of care workers seem necessary, building off existing studies (e.g. Farbenblum 2017; Flecker and Healy, 2015; Calenda, 2014).

The role of the recruitment process in shaping the employment situation of migrant care workers in destination countries was not tackled in this section. Based on many studies on labour migration generally, and on migrant domestic and health-care workers, systemic misconduct and malpractices often create the conditions for, or directly cause, many of the abuses and violations of migrant workers' rights (Farbenblum, 2017; Flecker and Healy, 2015).

High recruitment costs also expose migrants to debt and abuse. The international legal framework clearly underscores the fact that recruitment fees must not be borne by the worker (Private Employment Agencies Convention, 1997 (No. 181)). However, charging migrants fees remains a common practice globally and is permissible by law in several countries, although there is usually a ceiling on how much the worker can be charged. The ILO work under the Fair Recruitment Initiative shows that, in some countries where recruitment fees are illegal (e.g. in the Philippines for migrant domestic workers), some recruitment agencies require workers to attend pre-departure skills training, for which they charge migrants excessively high fees (collusion between recruitment and training centres), but the training provided has no relevance to the work to be performed (Gallotti, 2015). There is evidence that, in order to cover recruitment fees and other related costs, potential migrants and their families often incur heavy debts, which make them particularly vulnerable to exploitation and, in the worst cases, to debt servitude and other forms of forced labour (Gallotti, 2015). Once abroad, migrants often have to pay considerable deductions from their salary to repay their debts, and will hesitate to leave abusive work situations because of these financial obligations.

4.2.7. QUALITY OF CARE AND WORKING CONDITIONS OF CARE WORKERS

The quality of care is a common concern and interest shared by both care recipient and care worker. However, care policies most often take only the viewpoint of care recipients and their families:

their right or freedom of choice, security of the right to care, affordability of care, the need to balance care with family responsibilities, and standards of the care service and qualifications of the caregiver. Regulation of care services and the qualifications of the care workers, and training and registration of care workers are some of the major ways in which governments have tried to raise the quality of care.¹⁷⁰

However, little or no attention has been accorded by policies to the conditions under which care workers provide care – their job and income security, health and safety, care workers’ own family responsibilities, and the care relationship between worker and carer. Yet, difficulties in recruiting and retaining trained and experienced native-born and resident care workers in long-term care have been traced partly to the prevalence of low pay, poor working conditions and career prospects and low status of these care jobs. For example, interviews with migrant care workers engaged in home care in Canada talked about the increasing acuity of illness of patients, unsanitary conditions in which home-care patients live, the occupational health and safety risks these imply, physical and verbal abuse and sexual harassment; heavy workloads; high level of isolation, stress and burnout, and racial discrimination from co-workers and care recipients (Bourgeault et al., 2009). On top of these demands and risks, many migrant care workers complained of low levels of pay, few fringe benefits, job insecurity, and a lack of career and training opportunities. These difficulties and concerns are bound to affect work performance and retention of care staff, and thus the quality of care. High turnover rates among childcare workers and older person care workers reduce the consistency and quality of care that children or older persons need to receive to meet their basic needs, as well as their emotional needs (Folbre, 2006, pp. 21–22).¹⁷¹

One neoclassical view posits that raising wages for nurses could attract the “wrong sort” of person, one who does not have the “vocation” for nursing or caring for disabled persons (or teaching) (i.e. one who will undertake this work “beyond the call of duty”, because they like doing it) (Heyes, 2003). According to Heyes, if somebody without a vocation becomes a nurse, she or he would give the quality of care commensurate to the wage; while somebody with a vocation receives not only the wage but also a non-pecuniary benefit, and would thus provide good care.

Nelson and Folbre (2006) point out that Heyes’ argument disregards considerable literature on quality of care, worker motivation and morale, and ignores actual nursing shortages. They argue that, while vocation may be a necessary condition for high-quality performance in many jobs, it is by no means a sufficient condition; vocation does not guarantee skill. People with real financial responsibilities for themselves and their families would find it difficult to choose a low-wage nursing job, no matter how generous their hearts are. Workers who are willing to accept a low wage for nursing might do so because their opportunity costs (in terms of jobs foregone or career prospects) are low or may have other motivations (e.g. to obtain a residency visa or work permit). Nelson and Folbre further argue that higher wages would attract a higher proportion of truly caring, quality, skilled workers for whom decent wages are a necessity. A reasonably high wage can make it possible for a caring (feeling) person to choose to train for an occupation that includes a significant caring (activity) component. If high rates of pay are given in such a way that nurses feel respected and rewarded for their care and professionalism, feelings of vocation can be reinforced and expanded. An empirical study would be needed to establish these points definitively.

Because care provision is labour-intensive, improvements in these aspects are particularly challenging to achieve, especially in the context of public budget constraints. The country studies

¹⁷⁰ See examples of measures implemented in the United Kingdom, Cangiano et al., 2009, pp. 31–34.

¹⁷¹ Folbre cites high rates of turnover among childcare workers (averaging 40 per cent per year) and older person care workers (reaching almost 100 per cent within the first three months, in privately owned nursing homes) in the United States (Folbre, 2006, p. 21).

presented in this report show how cost-containment and cutbacks are translated into fewer and shorter visits with care clients and heavier workloads and longer shifts for care workers. Finding a balance between the interests of the care recipient and the care worker is an imperative, and as presented in section 5, initiatives taken by care workers and care recipients and employers of care workers show potential strategies.

4.2.8. IMPLICATIONS FOR GENDER EQUALITY

By focusing on migrant workers who look after young children and older persons and/or who provide care services to private households, the country cases and preceding discussion on employment and working conditions touched the core of the gender division of labour, i.e. of unpaid care and paid work and, thus, of the value of women's work, gender relations and equality. Returning to the questions posed in the Introduction to this report, are contemporary regimes regarding older person care, childcare and family/household care leading to a fairer valuation of women's work and care work, a better position for women in the care labour market and narrower inequalities between women and men in unpaid care obligations?

On the value of women's work and of care work: The country cases show that measures to contain or cut care costs, especially the costs involved in caring for older people and those needing long-term care, have often meant reducing the cost of care labour or finding a source of cheaper care labour: by shifting the delivery of care from institutions back to the family and relying on family caregivers, home-based care workers and domestic workers; by giving families greater responsibility in managing a "care budget" (for example, through cash-for-care allowances or Medicaid's self-directed services in the United States); by shifting care delivery from the state to the private sector, where wages and employment benefits tend to be lower; by creating cheaper employment models for personal and household care services (e.g. the "Alpha worker" or the "mini job" with fewer employment entitlements); through temporary foreign workers' schemes operating under highly restrictive and controlled regimes; and by (re)defining direct caregiving jobs as less skilled and creating various layers of care workers, from the most skilled, specialized professional at the top to the least skilled at the bottom in hierarchical terms but at the front line of care delivery. These trends imply a continuing low social valuation of care work, and of women's traditional care role.

On the gender division of care responsibility: First, the bulk of care needs continues to be met by the unpaid care labour of family members, relatives and friends, who are overwhelmingly women. Sweden is a rare example of a state policy and care culture that has encouraged and supported an equal sharing of care responsibilities and opportunities for paid work. With leaner budgets, however, the scope of publicly funded care has diminished over time and families are turning more to unpaid kin, to domestic workers who may be declared or undeclared, and to documented and undocumented migrants.

Second, most public subsidies, cash-for-care allowances and other state support measures enable private households to transfer or outsource (women's) unpaid care work to paid workers, who are in most cases also women, of a lower social class or different ethnicity, and migrant. This does not entail a redistribution of care responsibilities between women and men or a change in the gender ideology of care. Moreover, it may be that only well-off or high-income women and their households (not low-income women) are able to take advantage of the state schemes and outsource their unpaid care responsibilities to paid care workers. The evidence on special public subsidies to finance the employment of personal and household care workers in the EU indicates that it is high-income women who are able to take advantage of these schemes; while it is the long-term unemployed and the less-skilled who are expected to provide the labour for these services.

Third, tax-based public spending on childcare and older person care services has the potential to reduce women's burden of unpaid care work. Even better, this socializes the cost of care and shifts it from women to men, most of whom are economically active (and paid higher wages) and, therefore, tax-payers (Folbre, 2006). However, in general, still only a relatively small percentage of the cost of childcare and older person care is covered by public funding. With continuing fiscal pressures on public spending, it is not anticipated that this situation will improve in the near future, as evidenced by the cost-containment measures reported in the country cases.

5

AREAS FOR ACTION: ADVANCES, GAPS AND CHALLENGES

This section focuses on areas for action aimed at addressing issues related to the quality of care jobs and the employment situation of migrant care workers. Specifically, subsection 5.1 reviews major policy actions taken by key actors at international and national levels. It highlights some of their positive aspects, as well as gaps and pending challenges that would need to be addressed by future actions. Subsection 5.2 focuses on the collective voice and actions of the two key parties in the care relationship – the care recipients and their families and the care workers – and how, through organization and alliances, they have been able to (and could) achieve improvements in the conditions under which care is delivered, the working conditions of care workers and the quality of care. Mindful that the quality of care depends on the needs of both care recipients and care workers, this section tries to identify examples of good practice that respond to the interests of care recipients as well as care workers, and which enhance the positive role of third parties in this care relationship. Subsection 5.3 concludes with some proposed areas for further action.

5.1. WHAT HAS BEEN DONE: POLICY ACTIONS AND ISSUES

The previous sections of this report have considered global, regional and varying forms of inter-state initiatives and cooperation (bilateral, plurilateral and regional) that address some of the issues of international migration of skilled workers, including health and education professionals. They include international codes of practice to promote “ethical” recruitment and treatment of international health workers and teachers, bilateral and multilateral agreements between origin and destination countries, and strategies to improve workforce management in origin and destination countries. Most of these measures are non-binding initiatives and consultative forums, but they are important nonetheless in providing frameworks and principles for more coherent policies and actions. Significant measures introduced in destination countries include labour law reforms, standard contracts, collective agreements and migration rules that extend protection to hitherto unprotected workforces of the care economy, specifically “invisible”, often migrant, workforces providing care in home or family settings. In countries of origin, there have been actions to strengthen the regulation and supervision of recruitment practices and extend assistance to migrant workers throughout the migration cycle. However, despite these advances, gaps and issues remain.

5.1.1. CODES OF PRACTICE ON ETHICAL/FAIR RECRUITMENT OF CARE WORKERS

Some destination countries have adopted voluntary codes of practice for the recruitment of health professionals, teachers and domestic workers as a principal strategy for mitigating the adverse effects

of international migration of care workers on both the countries of origin and the migrants themselves, with varying outcomes. These codes have been adopted as a response to strong criticisms levelled against developed (resource-rich) countries for having actively recruited skilled professionals from resource-poor countries.

In health care, the most prominent among these is the *WHO global code of practice on the international recruitment of health personnel*. Other codes covering the ethical recruitment of health-care workers are: the *EU Blue Card Directive*; the UK Department of Health's *Code of practice for the international recruitment of healthcare professionals* for NHS employers;¹⁷² the *Commonwealth code of practice for the international recruitment of health workers*; the *Melbourne Manifesto* adopted by the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians; the European Hospital and Healthcare Employers' Association (HOSPEEM) and European Federation of Public Service Unions' (EPSU) *Code of conduct on ethical cross-border recruitment and retention in the hospital sector* (Yeates and Pillinger, 2013).

In the field of education, the *Commonwealth teacher recruitment protocol* has been recognized by UNESCO, ILO, the Organization of American States (OAS) and the African Union (AU) as an example of good practice.

There is certainly a great need for major improvements in recruitment practices. The coverage of the current codes needs to be widened considerably, to include such issues as the elimination of fees for migrant workers in accordance with the ILO Convention on recruitment agencies (No. 181). The ILO's *General principles and operational guidelines for fair recruitment* sets a benchmark. They underscore respect for the rights of all migrants throughout the recruitment process: "Recruitment should take place in a way that respects, protects and fulfils internationally recognized human rights, including those expressed in international labour standards, and in particular the right to freedom of association and collective bargaining, and prevention and elimination of forced labour, child labour and discrimination in respect of employment and occupation" (ILO, 2016b). In this regard, the ILO launched the Fair Recruitment Initiative in 2014 to help prevent trafficking in persons and forced labour, protect the rights of workers, including migrant workers, from abusive and fraudulent practices during the recruitment process (including pre-selection, selection, transportation, placement and possibility of return), reduce the cost of labour migration, and enhance development outcomes for migrant workers and their families, as well as for the countries of origin and destination.

5.1.1.1. Examples of codes of practice

A. WHO global code of practice on the international recruitment of health personnel

The WHO global code of practice on the international recruitment of health personnel, adopted in 2010, lays down and promotes voluntary principles and practices for the "ethical international recruitment" of health personnel. It discourages the active recruitment of health personnel from developing countries facing critical shortages of health personnel; emphasizes the importance of equal treatment for migrant health workers and the domestically trained health workforce; exhorts countries to implement effective health workforce planning, education, training and retention strategies to sustain a health workforce that is appropriate for the specific conditions of each country and to reduce the need to recruit migrant health personnel; encourages collaboration between

¹⁷² For a copy of 2004 version, see <http://www.nursingleadership.org.uk/publications/codeofpractice.pdf>.

destination and source countries, so that both can derive benefits from the international migration of health personnel; encourages member States to provide technical assistance and financial support to developing countries or countries with economies in transition and which are experiencing a critical health workforce shortage; and encourages member States to strengthen health personnel information and promote information exchange nationally and internationally (WHO, 2010a, 2010b).

Three articles of the WHO code of practice focus on the employment and labour rights of migrant workers [author's emphasis added]:

- Article 4.5: “Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.”
- Article 4.6: “Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country.”
- Article 3.8: “Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries.”

There has, however, been little assessment of the extent to which Article 4.5 and Article 4.6 have been implemented. Regarding Article 3.8, risks that circular migration schemes might make it difficult for migrants to access skills and career development opportunities, and that such schemes may result in less favourable terms of employment for migrant workers than for workers with regular status, have been pointed out (see subsection 5.1.3 below). This provision may run counter to the provisions on equality in workers' rights and access to professional development. According to the ILO, the protection of workers in destination countries seems to have been insufficiently addressed by the code.¹⁷³

Yeates and Pillinger's review of the implementation of the WHO code recognizes that it has helped to raise awareness among governments and stakeholders of human resources for health (HRH) migration issues and has provided an opportunity for research on regional health labour flows, although the review also notes that the code is short on implementation (Yeates and Pillinger, 2013, pp. 33–36). As of July 2013, 84 countries had established “designated national authorities” for reporting on the code and 54 countries had reported on the implementation of the code, the majority of which were from within the Europe region (but covering only 80 per cent of countries in Europe). A number of weaknesses in the code have been pointed out, foremost of which is the lack of clear mechanisms and methods for enforcing and monitoring its implementation (box 5.1).

¹⁷³ Yeates and Pillinger obtained the information from the ILO.

Box 5.1. WHO global code of practice on the international recruitment of health personnel

the following weaknesses have been identified in the code, based on a review of its implementation:

- *Lack of an enforcement system.* The code does not clearly identify which organization or government department is responsible for implementation of and monitoring of compliance with the code.
- *Translating principles into actionable instruments.* There has been insufficient guidance as to how the principles in the code could be translated.
- *Problems in obtaining data for monitoring compliance.* There is a lack of comparable data on HRH workforces in origin and destination countries. HRH migration statistics typically fail to capture medical professionals who migrate but do not work in medical jobs, working instead in private care homes and similar posts. Very few countries have fulfilled the reporting requirements.
- *Methodological difficulties in measuring success or effectiveness of the code* (Jensen, 2013). Changes in international labour markets are subject to a variety of national and regional developments, so the effects of the code are difficult to isolate. Many indicators used in the Reporting Instrument are qualitative, complicating cross-country comparison.
- *Failure to address the reasons underlying health workers' desire to migrate* (Jensen, 2013, citing Buchan et al., 2010). Although the code encourages wealthier countries to support the strengthening of health systems in poorer countries (thus addressing some of the push factors), this has clearly not been given enough emphasis in the code's implementation to date. Given the push factors, however, the code cannot be seen as a standalone tool for addressing the health worker crisis in developing countries.

Source: Yeates and Pillinger, 2013; Jensen, 2013.

B. Commonwealth teacher recruitment protocol

The Commonwealth teacher recruitment protocol (CTRP) has been recognized by UNESCO, the ILO, the OAS, the AU and Commonwealth Heads of Government as an example of international good practice in managing the migration of teachers (Ochs and Yonemura, 2012/13). The CTRP outlines the rights and responsibilities of the various stakeholders: recruiting countries, source countries and recruited teachers. The document also deals with the role of recruiting agencies as well as the monitoring, evaluation and future actions required of member countries and of the Commonwealth Secretariat.

Participants at the Sixth Commonwealth Research Symposium on Teacher Mobility, Recruitment and Migration, convened in June 2011 in Ethiopia, felt that the principles of the CTRP could contribute towards: the implementation of policy frameworks for teacher migration, both voluntary and forced, including in emergency situations; making the management of forced migrants more responsive and effective; and providing greater international consistency in the ways that all migrant teachers are managed in AU member states. The review of the implementation of the protocol highlighted the complexity and breadth of the issues around teacher recruitment and migration, indicating the necessity for engagement with a wider group of stakeholders than initially anticipated and many more awareness-raising activities if teachers' rights are to be protected effectively (box 5.2).

Box 5.2. Commonwealth teacher recruitment protocol: Implementation review findings

The main findings of the review of the implementation of the CTRP commissioned by the Commonwealth Secretariat were as follows:

- Context is central to the implementation of the CTRP, with macro issues determining both migration flows and labour demand and influencing teachers' individual choices to migrate.
- Implementation of the CTRP extended well beyond the work of the stakeholders mentioned within the document itself. A much wider group of stakeholders – including schools, consultants, academe, ministries of labour and immigration and qualification agencies – are part of what has been called a system of teacher migration and are crucial to the wider implementation and awareness-raising activities for teachers whose rights are to be protected.
- Ministries of education are not capturing data on teacher movement. The migration routes reported by teachers themselves were distinctly different from those reported by ministries, which reflect more organized recruitment. With respect to education policy, it is important to distinguish between teacher supply (the absolute number of teachers) and teacher deployment (the locations where the teachers are working). Although a country might have achieved its target numbers for teacher supply, the teachers must also be deployed where they are needed, which includes remote or unattractive areas.
- Individual teachers are choosing to work in a variety of different countries and serial migration is not uncommon. Recruitment initiatives can come from recruitment agencies, individual schools, local education authorities (school districts) or education ministries.
- The majority of teachers in the CTRP implementation review were unaware of the protocol. Evidence suggests that there is a strong need to improve advocacy for and engagement of teachers, to raise their awareness of their rights and the complaints mechanisms that are available.

Source: Ochs and Yonemura, 2012/13.

C. UK Code of practice for NHS employers

Among countries that have established national codes of practice for the recruitment of international health personnel, the United Kingdom was a pioneer. The UK Department of Health (DoH) first attempted to limit the negative effects of its recruitment practices on origin countries with health worker shortages in 1999 by launching guidelines to limit recruitment from South Africa and the West Indies. It subsequently launched a code of practice for NHS employers involved in the international recruitment of healthcare professionals, which was then further strengthened in 2004 (box 5.3). The adoption by the United Kingdom of its code of practice is noteworthy because the United Kingdom has long relied on international staffing of its health-care sector. In the past 20 years, the share of international registered nurses has increased, reaching approximately 18 per cent of the total nurse workforce in the United Kingdom, but their share began to decrease from the mid-2000s (Calenda, 2014). The DoH code's proclaimed aim is to preclude recruitment actions that might be detrimental to the health systems of developing countries. In this regard, it sought to limit the "active recruitment" of health professionals from certain areas, delineating where active recruitment could take place.

While the UK code may be regarded as a response to the negative consequences of its recruitment campaigns in developing countries, its adoption coincided with political and economic changes in the

United Kingdom: the end of a period of rapid expansion of the NHS,¹⁷⁴ the 2008/09 economic crisis and progressive cuts in NHS funding, and restrictions on the immigration of skilled health-care staff (Calenda, 2014, p. 2). The decline in the number of newly registered health workers after the mid-2000s has been traced not to the UK code, but rather to declining demand, more stringent registration conditions and changes in visa and employment requirements (Jensen, 2013, p. 32).

Box 5.3. United Kingdom: Limiting negative effects of recruitment through national voluntary codes

The UK Department of Health (DoH) first attempted to limit the negative effects of its recruitment practices on origin countries with health worker shortages in 1999 by launching guidelines to limit recruitment from South Africa and the West Indies. In 2001, the DoH subsequently launched a code of practice for international recruitment for NHS employers, the first of its kind on a country level. By adhering to the code, employers pledged to refrain from the “active recruitment” of health professionals from developing countries, unless there was a government-to-government agreement. (Such bilateral agreements existed between the United Kingdom and India, the Philippines and China, while the list of countries to be covered by the code – a list developed by the DoH and the Department for International Development (DFID) – included 154 countries by 2007.) In addition, the code set out procedural guidelines for international recruitment, covering aspects of recruitment, selection, induction and equal opportunities in employment, pay and career prospects. In 2004, the code of practice was strengthened, to extend to recruitment agencies working for the NHS and private sector organizations providing services to the NHS.

The guiding principles of the UK *Code of practice for the international recruitment of healthcare professionals* for NHS employers are as follows:

- International recruitment is a sound and legitimate contribution to the development of the healthcare workforce.
- Extensive opportunities exist for individuals in terms of training and education and the enhancement of clinical practices.
- Developing countries will not be targeted for recruitment, unless there is an explicit government-to-government agreement with the United Kingdom to support recruitment activities.
- International health-care professionals will have a level of knowledge and proficiency comparable to that expected of an individual trained in the United Kingdom.
- International health-care professionals will demonstrate a level of English language proficiency consistent with safe and skilled communication with patients, clients, carers and colleagues.
- International health-care professionals legally recruited from overseas to work in the United Kingdom are protected by relevant UK employment law in the same way as all other employees.
- International health-care professionals will have equitable support and access to further education and training and continuing professional development as all other employees.

Source: Becklake, 2008, pp. 23–24; Jensen, 2013, p. 30; United Kingdom Department of Health, 2004, pp. 7–9.

¹⁷⁴ In 1998, under favourable domestic economic conditions, the Labour under Tony Blair initiated a policy of massive NHS workforce expansion across all health professions. This fostered a period of active international recruitment. Memorandums of understanding with India and the Philippines, among others, were signed in order to facilitate international recruitment. A combination of factors, such as attractive wages, good working conditions and career prospects, lax immigration laws and historical linkages, aligned with both the desire and the desperate need felt among thousands of nurses from less developed countries to emigrate to the United Kingdom in search of a better life (Calenda, 2014, p. 4, citing several sources).

Becklake (2008, pp. 26–29) and Calenda (2014, pp. 33–34) point out weaknesses of the UK code of practice for the NHS. The limitations set out below might be common pitfalls of controls established by bodies on particular recruitment channels:

- The original 1999 code did not cover recruitment by the private sector or the recruitment of temporary staff, which were both avenues through which health professionals entered the United Kingdom.
- By blocking recruitment from South Africa and the West Indies, recruitment simply shifted to India and resource-poor sub-Saharan African countries (Ghana, Nigeria and Zimbabwe).
- The availability of data was insufficient for monitoring the numbers of migrant health workers who came into the United Kingdom via “active recruitment” from banned source countries and or came on their own, through migrant networks or via private health centres before switching later to the NHS.
- Unfair practices in the recruitment of health workers are not limited to nurses – a predominant concern of the code. Unethical recruitment was affecting older person care workers, a key workforce within the United Kingdom’s social care sector.
- Recruitment chains can be complex, especially in countries in which informal and illegal mechanisms of recruitment are widely diffused.

5.1.1.2. Are codes of practice effective?

Codes of practice for international recruitment are voluntary. While these codes are an important development, without a statutory mechanism for ensuring compliance, implementation will be fraught with difficulties. There is nonetheless room for enhancing the positive contribution of codes of practice to fair recruitment and employment of migrant care workers. Experiences point to a set of common major challenges that need to be addressed: inadequacy of data and methods for monitoring and assessing practices in destination and origin countries; plurality of policy actors and stakeholders who need to be engaged to implement various provisions of codes; complexity of recruitment channels, involving informal and illegal mechanisms; and complexity of the care system itself, such that guidelines may address one segment or category of workers and miss another equally important segment (e.g. nurses in public institutions but not care workers in the private or home-based sector). The role of workers’ and employers’ organizations in monitoring recruitment and employment practices has probably not been given enough attention. For the UK Code of practice for NHS employers, an informal network for NHS employers through which communication and reputation could circulate and be checked, has proven to be a fairly effective tool for monitoring recruitment agencies and enabling a “positive selection” among the agencies (Calenda, 2014, p. 34). Migrant workers could very well have little choice or information, meaning that they have no option but to accept the unfavourable terms offered by private recruitment agencies. In this regard, organizations of care workers (teachers, nurses, caregivers, etc.) and trade unions in both origin and destination countries, could extend their information and advisory services to migrant and would-be migrant workers, and exert pressure on duty bearers to meet their obligations.

5.1.2. INTER-STATE INSTRUMENTS: BILATERAL LABOUR AGREEMENTS AND MEMORANDA OF UNDERSTANDING

Bilateral labour agreements (BLAs) and memoranda of understanding (MOUs) are other types of instrument that have been used by governments of countries of destination and countries of origin to manage the movement of temporary workers between them, as well as to set a broad framework for

terms of employment of migrant workers in the host countries. It is important to note that BLAs have been concluded (with increasing occurrence) on the migration of domestic workers, for example by Saudi Arabia with countries such as Uganda, Ethiopia, Somalia and the Philippines.

5.1.2.1. Trends and practices: Objectives and provisions

Wickramasekara (2015) provides a comprehensive review of BLAs and MOUs concluded between two states. Both types of instrument could be important as mechanisms for protecting the rights of migrant workers and mitigating the negative impacts of outward migration. A BLA describes in detail the specific responsibilities of, and actions to be taken by, each of the parties, with a view to accomplishing their common goals. Unlike codes of practice, BLAs create binding rights and obligations. An MOU comprises a set of general principles of cooperation, describing broad concepts of mutual understanding, goals and plans shared by the parties. MOUs are usually non-binding. The use of BLAs dates back to the early 1990s, when states played a key role in organizing and closely supervising recruitment, employment and return (guest worker programmes of Europe). The post-1990 period has seen the most remarkable increase in the use of BLAs, but instead of simply organizing recruitment and deployment, the new generation of BLAs have a wider array of functions and objectives, which can be summarized as: promote regional integration; control migration in an irregular situation and ensure readmission; promote cultural ties; ensure that stays are temporary; promote migration and development linkages; and protect the rights and promote the welfare of migrant workers. Bilateral agreements that encourage temporary and circular forms of migration have also been increasing. The growth of post-1990 agreements has been traced to several factors: continuing labour demand from oil-rich GCC countries, the emergence of new countries of destination in southern Europe (Greece, Italy, Portugal and Spain), the break-up of the former USSR, the European Union's increasing influence over EU immigration policy and the growing recognition of migration and development linkages.

BLAs are relatively more popular among countries in Africa, Europe and the Americas, while the looser form of agreement, MOUs, appear to be the preferred instrument among Asian and GCC countries. The preference for the more flexible MOUs may be because destination countries in the GCC and South-East and East Asia have a ready access to a plentiful supply of low-skilled migrant workers from Asian countries. It is thus not imperative to secure this labour supply through a formal agreement. There may also be concern among destination countries that a bilateral agreement with one country would encourage further requests from other origin countries for similar agreements. Another reason offered by destination countries is that labour recruitment is usually a private sector business conducted in a market-oriented system and therefore government intervention is not required (Wickramasekara, 2015, p. 22).

Wickramasekara (2015) noted the following trends regarding the contents of inter-state agreements.

- Fewer agreements refer to the protection of migrant workers as an objective than to facilitating or regulating migration flows and employment of migrants, strengthening ties and cooperation and preventing migration in an irregular situation. However, more recent MOUs and BLAs between countries of origin in Asia and their corresponding destination countries (e.g. an agreement between the Philippines and Saudi Arabia on domestic workers) tend to refer to the protection of the rights of workers and employers.
- Almost no agreements consider gender-specific issues, even though women comprise a huge and growing share of migration flows, largely into care work and other services. The recent trend for dedicated agreements covering migration into domestic work may be considered a good practice

given that domestic workers are generally excluded from national labour legislation, especially in GCC countries and Asia.

- Provisions for monitoring and assessing implementation are weak or lacking. There are serious information gaps on the agreements and their operation, and a lack of clear assessment criteria and procedures and of resources for monitoring and evaluation.

Yeates and Pillinger (2013, pp. 17–18) have identified some emerging practices among bilateral agreements concerning health workers.

- A memorandum of agreement (MOA) between the Philippines and Bahrain on health services cooperation has been cited as an example of good practice in using the ILO decent work standards and ethical recruitment principles. The MOA provides that: “Human resources for health recruited from the Philippines shall enjoy the same rights and responsibilities as provided for by relevant ILO conventions”. An ethical framework for the recruitment of health workers was established through a partnership between Philippine and Bahraini health-care and educational institutions and was designed to enhance international education and professional development. The agreement covers an exchange of HRH in recruitment, rights of workers, capacity building, sustainability of the development of HRH and mutual recognition agreements on qualifications. The agreement also covers scholarships, academic cooperation on HRH and technology cooperation, and specifies the reintegration of HRH who return to their home country.
- Equality of treatment has been embedded in an agreement between Spain and the Philippines, which provides for nurses and other highly skilled Filipino workers to work in Spain with the same protection and rights as Spanish workers.
- Some bilateral agreements have been used as a basis for the recognition of qualifications. A United Kingdom–Spain agreement gives recognition to Spanish nurses’ skills in the United Kingdom. Cooperation agreements for training, research and development include the provision of training for South African doctors in Cuba, Iran and Tunisia and temporary recruitment of doctors and qualified health personnel from Cuba, Iran and Tunisia to fill labour shortages in the health sector in South Africa.
- The Economic Partnership Agreement signed between Japan and Indonesia provides for a quota of nurses and nurse specialists from Indonesia to work as caregivers or assistant nurses at hospitals or nursing homes for older persons in Japan. The agreement includes a requirement for Indonesian nurses to take Japanese language lessons.

With a view to enhancing the protection of migrant domestic workers, some countries of destination, including Hong Kong (China), Jordan, Lebanon and Malaysia, have adopted standard employment contracts and entered into bilateral agreements with countries of origin. The development of “model contracts of employment” is specifically recommended by the Domestic Workers Recommendation, 2011 (No. 201) and their adoption has been welcomed as an improvement and a step towards the formalization of the employment relationship and the promotion of equal treatment between migrants and nationals, based on minimum standards.

5.1.2.2. Are BLAs and MOUs effective?

Wickramasekara (2015) noted that the lack of data on the actual situation in destination countries made it quite impossible to properly assess the effectiveness of BLAs and MOUs. Makulec (2014), who looked at the Philippines’ bilateral labour agreements with Bahrain, Japan, Norway, Spain and the United Kingdom, covering health-care professionals, confirmed the lack of monitoring and evaluation mechanisms in the agreements.

Makulec's study (2014) yields valuable insights into what such agreements could feasibly achieve, both in terms of facilitating recruitment and protecting migrants' rights. One of the main challenges in negotiating and implementing bilateral agreements was the asymmetry of power between the parties. Implementing negotiated agreements was especially difficult when (i) the receiving country could recruit workers even in the absence of the agreement (in the case of Saudi Arabia) and (ii) the scope of the agreement was partial, i.e. it covered only the public sector but not private organizations (e.g. the United Kingdom).

Standard employment contracts, which are provided for in BLAs covering domestic workers, often do not align with the minimum standards provided by Convention No. 189. Indeed, they usually provide weaker protection than most labour laws as they would not be enforceable in the same way (Gallotti, 2015).

While BLAs, MOUs and standard employment contracts may be regarded as positive protection measures, it is important to note that they should complement labour legislation, and that they do not constitute adequate legal protection on their own. Although their wide-ranging objectives might include protection of workers' rights (and this appears to be the trend), such protection might not receive substantive attention (if any at all) in provisions and measures. For example, Anderson (2016), who reviewed MOUs between Thailand and three main countries of origin (Myanmar, Cambodia and Lao People's Democratic Republic) on migrant domestic workers in Thailand, notes that in fact these agreements are very much focused on admissions, prevention of irregularity and repatriation.

In the absence of national legal protection for migrant workers, bilateral agreements might be the next best thing. However, enforcement and monitoring of actual practices on the ground in destination countries is notably lacking, which casts doubt on the sincerity of the parties to the agreements. There are no data on which to base a real assessment of the effectiveness of BLAs and MOUs.¹⁷⁵

5.1.3. BILATERAL AGREEMENTS THAT PROMOTE CIRCULAR MIGRATION: DIFFERENT VIEWS

Recently, an increase in the number of bilateral agreements promoting "circular migration" has been noted (Wickramasekara, 2015), which merits some further attention. Circular migration refers to temporary movements of a repetitive nature, across borders, either formally or informally, usually for work, involving the same migrants (Wickramasekara, 2011).¹⁷⁶ One can distinguish two types of circular migration: spontaneous circular migration, which occurs when migrants from origin countries, or migrants in destination countries, engage in back and forth movements; and managed or regulated circular migration programmes (CMPs). CMPs have recently been promoted as a triple-win solution for the three parties in the migration process – the country of destination, the country of origin and the migrant worker – as they address some of the most contentious migration issues: meeting labour market needs in destination countries without permanent settlement; mitigating the "brain drain" in home countries; promoting development in home countries, through a steady flow of remittances, the acquisition of skills and enterprise creation; and minimizing migration in an irregular situation.

The case of Germany (refer to subsection 4.1.4.1) provides a concrete example. Eastern European nationals, with the right of freedom of movement within the EU, move back and forth regularly between their home country and Germany, where they provide older person care services, either through the mediation of employment agencies or independently.

¹⁷⁵ Several provisions of the much-praised bilateral agreement between the Philippines and Saudi Arabia reportedly remain unimplemented, e.g. mandatory day off or rest day, salary paid via ATM (personal communication with Susan Ople, President of the Blas F Ople Center).

¹⁷⁶ While circular migration can be differentiated from permanent migration (for settlement) and return migration (one trip migration and return), there are nevertheless interfaces between them, with circular migration in some cases leading to permanent migration or final return (Wickramasekara, 2011).

While managed circular migration could generate remittances, reduce the brain drain and minimize overstaying by migrants, it gives rise to a number of issues (Wickramasekara, 2011). The short duration of contracts, especially for non-seasonal work, directly affects migrants' capacity to contribute back home. The re-migration process itself may involve high costs, which cannot be fully recovered by migrants. Labour brokers and intermediaries can find many opportunities to defraud migrants. The undue power of employers in the selection of workers and in re-nominating them for subsequent visits has been noted in a number of seasonal work programmes. While migrants are expected to bring back skills, it is unlikely that employers would invest in training circular migrants in lower skilled categories. The short duration of contracts may mean that workers may be denied most of the assistance needed to work and live in destination countries. Frequent separations from families at home also involve social costs.

Global trade unions have been particularly critical of temporary and circular migration programmes as they can lead to precarious and exploitative work and diminish workers' rights to training, career development, decent work and family reunification (ITUC, 2011; PSI, 2009). They argue that such programmes are only sustainable if they promote the development of the skills and human resources necessary to strengthen public service delivery in both the origin and destination countries and facilitate knowledge transfer to and "brain gain" in low-income countries. However, such programmes are prone to abuse by unscrupulous employers if they are implemented in the absence of government regulation, application of human rights and labour standards, ethical recruitment guidelines, full transparency and involvement of trade unions.

5.1.4. EXTENDING LEGAL PROTECTION TO MIGRANT CARE WORKERS

For a long time, labour legislation has excluded domestic workers from labour and social protection and, to date, at least 30 per cent of domestic workers globally are without any form of labour protection (ILO, 2013). In three regions, the proportions of domestic workers excluded from legal protection are higher than this global average: at 99 per cent in the Middle East, 61 per cent in Asia and the Pacific and 45 per cent in Eastern Europe and Commonwealth of Independent States (CIS) countries. Yet, domestic workers make up the hidden backbone of care economies – they work in and for private households, perform housework (non-relational care work), childcare or older person care, or care for sick and disabled members of families.

Since the adoption of the Domestic Workers Convention, 2011 (No. 189) and Recommendation No. 201, 25 countries (as of September 2018) have ratified the Convention, most of them in Latin America (Argentina, Belgium, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, Finland, Germany, Guinea, Guyana, Ireland, Italy, Jamaica, Mauritius, Nicaragua, Panama, Paraguay, the Philippines, Portugal, South Africa, Switzerland, and Uruguay). Moreover, an increasing number of countries have adopted policy, legislative and institutional reforms aimed at extending or improving the protection of domestic workers' labour and social rights and working conditions. Some of these reforms are comprehensive, addressing all domestic workers in an employment relationship and many aspects of their terms and conditions of employment (ILO, 2016a). Recent examples are Spain's Royal Decree 1602/2011 and Ley 27/2011 on social security, passed in 2011, and Law 26,844 passed in Argentina in March 2013 (box 5.4).¹⁷⁷ Others have introduced or reformed labour standards in one or several parts of the conditions of employment, such as remuneration or working time. For instance, in the United States, in 2013, the scope of coverage of the federal minimum wage and working

¹⁷⁷ The Spanish Royal Decree was amended in 2012 to make it the responsibility of domestic workers who work only a few hours per employer to register with the social security system. This has been criticized because it could make it harder for workers to gain social security coverage.

time protections were extended to caregivers (Goldberg, 2015); in Switzerland, in 2011, a national standard employment contract was adopted that set a minimum wage for domestic workers (Graf, 2013); in Chile, in 2014, the labour law was reformed to limit working time for live-in domestic workers; in Singapore, in 2013, domestic workers were granted a weekly rest day; and in Thailand, in 2012, a ministerial order was adopted that provides paid annual leave, paid holidays and weekly rest to domestic workers. All these countries are destinations for migrant domestic workers. While of limited scope, these measures reinforce the legal recognition of jobs in domestic work. They also emphasize that such work should be treated like any other, in that it involves an employment relationship under state surveillance, and is not simply a private matter. To date, there is little empirical data on the impacts of these legal reforms on migrant and native domestic workers.¹⁷⁸

Domestic workers in the EU and Latin America are relatively better protected by labour legislation than those in Asia and the Arab regions. However, granting domestic workers protection under national labour laws might not suffice to guarantee that migrants can effectively access decent work opportunities in the sector because migration law often prevails over labour law (particularly in relation to migrant workers in an irregular situation). In the EU, labour law applies to migrant workers who are in a regular situation. However, it seems that there are “no express prohibitions in domestic law which could prohibit migrants in an irregular situation from accessing remedies for labour law violation” (FRA, 2011, p. 53). There are several rights that can still be enforced in cases of irregular migrant status under EU law. In at least 19 countries, entitlements to fair remuneration apply to all workers, including migrants in an irregular situation. The EU Employer Sanctions Directive 2009/52/EC contains an important safeguard to address exploitation regarding wages.¹⁷⁹ According to Article 6, EU Member States must make available mechanisms to ensure that a migrant in an irregular situation may either introduce a claim against an employer for any remuneration due or may call on a competent authority of the EU Member State concerned to start recovery procedures. Back payments should at least be “as high as the wage provided for by the applicable laws on minimum wages, by collective agreements or in accordance with established practice in the relevant occupational branches” (Article 6a). In the majority of EU Member States, irregular residence does not nullify a person’s rights as a worker or the effects of labour laws, although, due to an absence of case law, the situation is often unclear or subject to interpretation (Gallotti, 2015). However, there are obstacles that make it difficult for migrants in irregular situations to claim their rights in court: fear of detection, limited or no security of residence, low awareness of rights and the need to provide proof of the existence of a work contract (FRA, 2011, p. 54).

In Asia and the Middle East, which host large numbers of migrant domestic workers from Asian and African countries, there have been a few improvements over the past decade in terms of the regulatory protection of migrant domestic workers.¹⁸⁰ For example, in Jordan, domestic workers are not covered by Jordan’s labour law but are covered by a separate regulation (Regulation 90). In 2012,

¹⁷⁸ A study on the outcome of Spain’s Royal Decree 1602/2011 was commissioned by the ILO. Because the reform coincided with the worst effects of the 2008 economic crisis, the effects of the law could not be isolated. Household incomes declined at the same time as the hiring of domestic workers formally became more costly. The numbers of migrant domestic workers also fell; and Spanish nationals increased their share of the sector. Campaigns on domestic workers’ rights and social security registration tapered off after 2012. Enforcement of the new laws was lax despite complaints being filed by domestic workers’ organizations (Díaz Gorfinkel and López, 2015).

¹⁷⁹ Directive 2009/52/EC of the European Parliament and of the Council of 18 June 2009, provides for minimum standards on sanctions and measures against employers of illegally staying third-country nationals. In brief, the Directive urges Member States to intensify “measures against illegal employment”, and to guarantee effectiveness of measures through criminal penalties in serious cases, such as “the illegal employment of a significant number of third-country nationals, particularly exploitative working conditions, the employer knowing that the worker is a victim of trafficking in human beings and the illegal employment of a minor”. For more details see https://ec.europa.eu/anti-trafficking/legislation-and-case-law-eu-legislation-migration-law/directive-200952ec_en.

¹⁸⁰ Abuses and violations of human rights and labour exploitation of domestic and other migrant workers in these regions are well-documented.

Singapore legislated for one rest day a week for migrant domestic workers, effective from 2013. Most recently (31 May 2017), the UAE Federal National Council passed a new law guaranteeing protections for domestic workers (still to be signed by the UAE President). This new law regulates employment contracts, sets out the rights of domestic workers and any legal prohibitions, and regulates recruitment agencies (Gulf News, 2017). Despite these improvements, reforms have been partial and slow in Asia and the Middle East (Begum, 2017; Human Rights Watch, 2010). Instead of using labour legislation to provide protection for migrant domestic workers, governments have relied on standard employment contracts or BLAs, which have suffered from poor levels of enforcement. Immigration policies continue to give employers, as sponsors to whom a migrant's fixed-term visa is tied, inordinate control over their domestic employees.

Laws that recognize and protect migrant workers' rights are indispensable. But it is also important to bear in mind that legislative reforms are quite slow to occur, legal provisions may be inadequate and legal protections are insufficient to be effective. Weak institutional enforcement capacities, traditional practices, cultural norms and attitudes, lack of information on the part of employers (especially private households and frail, older employers) and workers and irregularity of workers' legal migrant status are among the factors that hamper compliance with legislation (ILO, 2016a).

Box 5.4. Recent legal reforms extending recognition of domestic workers' labour rights

Argentina, 2013: The new domestic work law, Law 26,844, extended the benefits enjoyed by other workers to domestic workers. It provides for a maximum number of working hours (48 hours per week), a weekly rest period, overtime pay, annual vacation days, sick leave, maternity protections and a minimum age of employment. The law also provides additional protections for live-in domestic workers, such as a provision for breaks and an entitlement to a furnished room. This reform also repealed the former discrimination against certain groups of domestic workers according to the number of hours they worked, by now considering any number of hours worked in a private household as domestic work.

Philippines, 2013: The Domestic Workers Act (2013) is a comprehensive law that provides for the protection of domestic workers against abuse, debt bondage and the worst forms of child labour. The Act sets minimum standards for wages, working hours and days of rest, and other benefits for domestic workers; extends social security, public health insurance and a low-income housing scheme to the sector; and provides for mechanisms for labour dispute resolution and quick response to abuses.

Spain, 2011: Royal Decree 1620/2011 sets out requirements for a minimum wage, weekly and annual leave, maternity leave and compensation for stand-by time. This regulation put domestic workers on par with employees on issues such as wages (which must be not less than the minimum inter-professional wage), while limiting the statutory working week to 40 hours with 12 consecutive hours of rest. Furthermore, it regulates the amount that can be deducted from the wage for accommodation and maintenance. Spain has also incorporated social security for domestic workers into its General Social Security Scheme.

Note: Although the Philippines is not a destination country for international migrant domestic workers, the adoption of the comprehensive law protecting domestic workers sends a strong message to countries of destination, which host thousands of Filipino domestic workers, that the Philippine Government is committed to the principles set out in the Domestic Workers Convention 2011 (No. 189).

Source: ILO, 2016a, p. 33.

5.1.5. RESTRICTIONS ON WOMEN'S MIGRATION

An instrument that has been used by governments to protect their female nationals from abuses, trafficking and forced labour overseas is to bar them (or those below a certain age) from seeking employment in certain occupations which are considered “risky”. Recent years have seen bans or age barriers being imposed by some countries of origin in Asia (e.g. Cambodia, Indonesia, Myanmar, Nepal and the Philippines) on their women nationals wishing to migrate for domestic work in destination countries in Asia (e.g. Malaysia and Singapore) and the Middle East (e.g. Kuwait). These bans assume that domestic work in certain countries is likely to involve unacceptable working and living conditions, for which adequate protection measures are difficult to put in place (ILO Decent Work Team for South Asia, 2016). Countries of destination may also impose bans on migrants from specific countries, such as Hong Kong when it barred Nepalese contract workers (mostly women domestic workers) from entering in the mid-1990s (UNIFEM, 2009).

As a protection instrument, bans have proven to be ineffective and to lead to adverse and perverse consequences, and they violate the basic human rights of freedom to move and to equality of treatment.

Regarding the first of these rights, studies of bans on women's movement have made the following observations (ILO Decent Work Team for South Asia, 2016; Napier-Moore, 2017; MIGRANT and FUNDAMENTALS, 2015):

- Countries that impose bans and other policy restrictions on their citizens have no juridical power over the countries of destination, which can (and do) admit nationals from countries that have imposed a ban. For example, in 2014, Myanmar banned its citizens from migrating to Singapore to take up domestic work, but the high demand for domestic workers in the latter country led to an increase in the number of women from Myanmar who were issued domestic worker visas.
- Women throughout Asia migrate despite policies that aim to stop them. To get around these measures, they leave through non-official, irregular, clandestine and more risky channels. This makes them even more exposed and vulnerable to abuses and substandard working and living conditions, and places them almost beyond the reach of assistance and justice mechanisms. Undeclared and without an appropriate “paper trail”, these migrant women become much more dependent on their recruiters and employers.
- After introducing bans, both Myanmar and Cambodia saw the growth of unlicensed smaller recruitment agencies and individual recruiters who were ready to facilitate women's migration through irregular means. Some licensed recruiters also turned to illegal recruitment practices (e.g. not reporting a migrant is leaving or has left the country or falsifying the occupation of the migrant). Migrants leaving through these irregular and illegal channels often have no choice but to pay higher recruitment fees, which has repercussions for their indebtedness and future earnings.
- Migration bans have had little effect on working conditions in destination countries. While there are cases of improvements in some employer-households, the general situation remains unchanged, with poor working conditions and abuses. In the case of the age barrier introduced in Nepal, those affected by the barrier and those who were not had substantially the same work experiences.

Moreover, given the huge supply in Asia and Africa of female labour for domestic work, recruitment efforts simply shift from a banned country to a country without a ban. Bans are hardly effective bargaining levers for exacting better terms and conditions of employment.

On the issue of equality of treatment, bans discriminate against women's rights and violate international standards and norms. The ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111) is the most comprehensive instrument on non-discrimination and equality in the world of work and a

fundamental Convention. It requires States to adopt and implement a national policy to promote equality of opportunity and treatment, for all workers, nationals or migrant workers, in all aspects of employment and occupation with a view to eliminating discrimination, including gender discrimination in respect thereof. The ILO Equal Remuneration Convention, 1951 (No. 100) has the objective to promote and ensure equal remuneration for men and women for work of equal value, including for care workers, whether nationals or non-nationals. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) obligates states to take steps to eliminate discrimination against women on the basis of gender and to realize women's rights through equal access and opportunities.

Rather than imposing bans, effective protection would be better pursued through sustained advocacy for countries of destination to: ratify international conventions relevant to gender equality, migrant and domestic workers, introduce enforceable contractual instruments on rights of migrant workers, improve migrants' access to justice and redress mechanisms, and support women migrants' organizations and collective engagement (ILO Decent Work Team for South Asia, 2016). The ILO supervisory bodies, while being aware that measures to address structural abuse against women migrants are well intended, have considered that imposing a ban on women migrating for employment runs counter the principle of equality and restricts women's rights instead of protecting them. The CEAC has considered that measures such as investing in decent work opportunities at home and strengthening the protection of the rights of women migrants, including through international cooperation, may allow women who choose to migrate to do so safely and in an informed manner (ILO, 2016c, para 543).

5.2. VOICE AND REPRESENTATION FOR CARE RECIPIENTS AND CARE WORKERS

Care recipients and care workers share a "common interest" in finding socially optimal care arrangements that maintain the quality of care, its suitability with the needs of workers with care responsibilities as well as respect for care workers' rights. There is therefore a need for care recipients and care workers to have voice or an interlocutor, someone or some organization to represent their interests, individually and collectively, in dealings with the state and care-providing agencies.

5.2.1. THE RIGHT TO ORGANIZE: CHALLENGES AND BARRIERS

Under the Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87), the right to organize should be guaranteed without distinction or discrimination of any kind. When considering care workers, it is important to distinguish those who work in private home settings from those who are employed in establishments. For teachers, nurses and other care professionals employed in educational and health-care establishments, the freedom to form or join a trade union is generally an established right under national labour legislation. In almost all democratic countries, trade unions for these groups are among the most visible. Due to a lack of available information, this report cannot say how well migrant health and educational professionals are represented in trade unions and collective bargaining agreements or explain any exclusions.

For domestic care workers (home-based or in-home care workers), on the other hand, their right to join and participate in workers' organizations is usually not unrecognized, legally or socially. Being an immigrant or having an irregular or temporary migrant status may be additional barriers. The organizational experience of migrant domestic workers is relatively much better documented than that of migrant institution-based care workers. The ILO supervisory bodies have emphasized that the need to ensure not only that domestic workers are covered by the relevant legislation, but also that, in practice, they benefit from the guarantees set forth in the Convention (ILO, 2012, para. 93).

As regards care recipients and their families, no one will disagree that their views and concerns should be heard and addressed, but promoting their organization and collective representation is probably unimagined in most societies. Nonetheless, organizations of care recipients and their families do exist in a few countries, with some dating back more than a decade. Organizations of employers of domestic workers have also evolved, although much fewer than workers' organizations. These provide exceptional examples of what such organizations could do to improve care provision and the functioning of care systems. A few participate in collective bargaining.

For both domestic workers and the private individuals or households who employ domestic workers, there are challenges and barriers to self-organizing or to joining organizations of employers or workers, respectively (Hobden, 2015a, 2015b). One barrier is that both workers and employer households are widely dispersed, so have no opportunities for establishing shared issues, visions or goals. Unionizing may be regarded as anathema to the family setting and personal nature of their relationship. There may be legal and administrative barriers, such as an exclusion of domestic workers and/or migrant workers from the right to organize and engage in collective bargaining. For example, in Thailand, domestic workers are not allowed to organize and only Thai nationals are allowed by law to organize (Anderson, 2016). Because migrants tend to be dependent on their employer for shelter, basic needs and residency rights, fear of upsetting their employer and losing their job is a powerful deterrent. However, despite these challenges, home-based or domestic workers are becoming increasingly organized and are engaging in collective action and social dialogue.

5.2.2. VOICE AND ORGANIZATIONAL CAPACITY OF MIGRANT DOMESTIC WORKERS

At the 2014 May Day march in Basel, Switzerland, Polish women care workers looking after older persons in Switzerland took centre stage, carrying a large banner with the slogan “No more exploitation – We demand rights and respect!” Bozena Domanska, a Polish care worker, spoke and decried the practices of her employer, a private care enterprise, which was making large profits from exploiting Polish and Hungarian workers, paying very low wages for round-the-clock work. She announced the establishment of their network, *Respekt*, to give women care workers a voice in the fight against exploitation, to demand recognition of their work's contribution to society and to fight for fair wages and better financing of care work (Schilliger, 2016).

There are many examples of struggles by migrant care workers and domestic workers to organize in the face of many odds and in settings that do not welcome or favour such organizing efforts. For example, in Thailand, where migrants and domestic workers are not allowed by law to organize, they have formed a network within the Network of Domestic Workers of Thailand (Anderson, 2016).

The organizational experience of migrant domestic workers in Hong Kong (China), which, after many years and with the support of the Hong Kong Confederation of Trade Unions (HKCTU), led to the establishment of the Federation of Asian Domestic Workers Unions (FADWU) in 2010, presents a valuable learning opportunity (box 5.5). The FADWU unites six nationality-based unions of domestic workers (local Chinese domestic workers together with the unions of Bangladeshi, Filipino, Indonesian, Nepalese and Thai domestic workers); it represents their collective interests in dealing with the Hong Kong Administration and carries out sustained awareness-raising campaigns among migrant and native domestic workers and resident communities in Hong Kong (China). This experience highlights the important contributions that trade unions can make towards empowering migrant domestic workers and giving them a voice.

The South African Domestic Services and Allied Workers Union (SADSAWU), a union for local South African and migrant workers (mostly from Zimbabwe and southern African countries), has pursued a strategy of organizing and recruiting migrant domestic workers and raising migrant domestic workers' awareness of their rights (box 5.6).

Box 5.5. Federation of Asian Domestic Workers Unions (FADWU): Organizational process

Domestic workers in Hong Kong started to become organized in the 1980s, with migrant domestic workers setting up associations, assisted by non-governmental organizations, such as the Asian Migrant Centre (AMC), and faith-based organizations. The AMC helped to set up the first ever migrant domestic workers' union in the territory, the Asian Domestic Workers' Union (ADWU), which eventually disbanded in the 1990s due to internal conflicts. While this was a significant setback, many seeds had been sown and landmark victories won (e.g. annual salary increases, improvements in the standard contract, successful negotiations with the employers' association).

The next decade and a half witnessed a rapid increase in the number of domestic workers in Hong Kong and an upsurge in organizing, campaigning and advocacy for their rights, with the assistance of the HKCTU, AMC, Asian Migrants Coordination Body (AMCB), General Federation of Nepalese Trade Unions (GEFONT), Far East Overseas Nepalese Association – Hong Kong (FEONA) and Alliance of Progressive Labor (APL). The Filipino Migrant Workers Union (FMWU) was founded in 1998, the Indonesian Migrant Workers Union (IMWU) in 2000, the Hong Kong Domestic Workers General Union (HKDWGU) in 2001, the Filipino Migrant Domestic Workers Union (FDWU) in 2003, the Union of Nepalese Domestic Workers (UNDW) in 2005, the Filipino Overseas Domestic Workers' Union (ODWU) in 2008, and the Thai Migrant Workers Union (TMWU) in 2009.

Since its founding in 1990, the HKCTU has been actively involved in organizing migrant workers (mostly domestic workers). It extended support and assistance to the ADWU, in particular for its training programmes and running costs, organized awareness-raising activities, such as forums, meetings and rallies, aimed at making HKCTU members understand the importance of working with migrants, supporting their cause and allocating resources to help them build their own unions. The HKCTU organized local domestic workers, which led to the establishment of the HKDWGU. The FMWU, IMWU, FDWU and the TMWU affiliated to the HKCTU and worked together with the HKDWGU on issues of common concern. Their representatives sit on the Executive Committee of the HKCTU, bringing the views and concerns of domestic workers and migrants to the table and hearing those of Hong Kong workers. On 21 November 2010, FADWU held its founding conference, a major milestone in the organization of domestic workers in Hong Kong.

FADWU's individual member unions are well entrenched within their respective communities. They take the lead in pushing for domestic workers' and migrants' rights on the legislative front, both in Hong Kong and in their own countries. They provide various services (information, legal assistance, counselling, welfare and referrals) not only to their members but to non-members as well and, in general, enjoy the respect and goodwill of the community at large.

FADWU has slowly gained recognition in the Hong Kong community. Since its formal foundation, FADWU has intensified its lobbying and advocacy work. On 22 November 2011, representatives of the FADWU and HKCTU met with the Chairman of the Equal Opportunity Commission (EOC) to discuss the right of abode and the EOC's response to discriminatory reactions of the public. EOC responded positively to the request of migrant groups to consistently remind the public to avoid discriminatory language in its E-Newsletter. It now requires internet discussion forums to delete posts with racial slurs and comments.

The Hong Kong Employers of Domestic Helpers Association (HKEDHA) also welcomed the founding of the FADWU as a way to promote good working relations between domestic workers and their employers. One issue which both FADWU and HKEDHA support is more effective supervision of employment agencies; both agree that the practice by agencies of extracting excessive fees from domestic workers should be stopped and that agencies violating the law should be punished and blacklisted.

Box 5.6. South Africa – SADSAWU: New strategy for organizing South African and migrant domestic workers

A significant stream of migrant women from Lesotho, Mozambique, Swaziland and Zimbabwe migrate to South Africa to look for jobs as domestic workers. As most are undocumented migrants, they often experience inhuman labour conditions. Preliminary results from research on domestic workers in South Africa showed that migrant domestic workers tend to be much younger than their South African counterparts, with a higher concentration in the 15–20 year-old age group.

The challenge for SADSAWU has been to bring migrant domestic workers into its ranks as full and active members. However, many migrants fear joining the union, concerned that this would mean exposing their identity and irregular migrant status, and that they would lose their jobs once their employers learn about their union affiliation.

SADSAWU has recruited and organized domestic workers for many years. At a workshop in Johannesburg in 2015, in consultation with migrant domestic workers' organizations in South Africa, it formulated a new strategy aimed at strengthening and expanding its organizational efforts to all the nine provinces in South Africa. The strategy would include the following elements:

More efficient data gathering on migrant domestic workers for monitoring and evaluation purposes, and for determining where the migrant domestic workers can be found and how they can be mobilized.

Strengthened collaborative networks with existing non-governmental organizations and diaspora organizations that are already working with migrants, as well as the ongoing online registration of Zimbabwean migrants by the Zimbabwe Consulate in South Africa.

Development of a migrant domestic workers' pre-migration awareness information package, which would inform migrant domestic workers coming to South Africa about SADSAWU (what it does to promote domestic workers' rights, where it is, etc.) and other supporting organizations from which migrants can get assistance.

Source: Jinnah, 2015; ILO–EU project Global Action Programme on Migrant Domestic Workers, 2015.

There are many other examples of how trade unions in destination countries have organized and assisted migrant care workers: UPCAP in Argentina, FNV in the Netherlands, CSV and CSC in Belgium, and CFDT in France. In Lebanon, migrant domestic workers have formed a union with the assistance of FENASOL. In Malaysia, a major destination of migrant domestic workers (who are allowed by law to join unions), the Malaysian Trade Union Congress (MTUC) is assisting the Domestic Workers Association to be registered and legally recognized in the country (Anderson, 2016).¹⁸¹

In some cases, trade unions in countries of origin have entered into bilateral agreements with trade unions in countries of destination with a view to improving cooperation and enhancing workers' protection. For example, a bi-national agreement was reached in 2014 between domestic workers' organizations and trade union confederations in Paraguay and Argentina to promote decent work for Paraguayan migrant domestic workers in Argentina. A declaration and joint action plan to promote decent work for migrant domestic workers were also agreed between trade unions and domestic workers' unions in Lesotho, South Africa and Zimbabwe. Trade unions seek alliances with trade unions in other countries

¹⁸¹ Anderson (2016) reported that, at the time of writing, the Malaysian Government had rejected an application for registration of the Domestic Workers Association, filed by the MTUC.

that are part of the same “global care chain”. There are also trade unions in sending and destination countries that have succeeded in negotiating bilateral MOUs. GEFONT, a Nepalese trade union, has forged alliances with trade unions in countries that host Nepalese domestic workers, including Bahrain, Kuwait and Malaysia, to pursue improvements in their working conditions and migratory status.

In the United States, as mentioned in subsection 5.2.5, home care workers engaged by the government at county level waged campaigns in several states to gain the right to organize and bargain at state level. The period between early 2010 and October 2013 was a time of intense debate in several states over the widening of collective bargaining rights for home-based childcare workers (Blank et al., 2014). The debate on the right of care workers to organize has continued in the United States (Toland, 2015; Grindal, 2015). The specific case of home-based caregivers of Illinois, which describes how, through unionization, they have won the right to bargain directly with the state, is presented in box 5.7, below.

In Sweden, in the 1990s, two trade unions – *Kommunal* municipal workers’ union and *Lärarförbundet* teachers’ union – ensured that childminders employed by municipalities in day-care centres and pre-school teachers enjoyed the same rights as other employees in the sector, by organizing them and including them in collective bargaining (Morgan, 2005, p. 256).

5.2.3. VOICE AND ORGANIZATIONAL CAPACITY OF CARE RECIPIENTS AND THEIR FAMILIES

Care recipients and their families are important stakeholders because the availability and quality of care services is a key determinant of their ability to gain employment as well as the kind of employment arrangements they could engage in.

In France, various organizations represent employers (who may be private individuals or agency providers) of a range of domestic workers, such as care workers for older and disabled persons, childcare workers and home maintenance/cleaning workers. The *Fédération des Particuliers Employeurs de France* (FEPEM), formed in 1948, represents about two million domestic employers, most of whom are householders. Two employers’ organizations represent non-profit companies, the *Fédération Nationale des Associations de l’Aide Familiale Populaire-Confédération Nationale des Familles* (FNAAP-CSF) and the *Union Nationale de l’Aide, des Soins et des Services aux Domiciles* (UNA), and two employers’ organizations represent private companies, the *Fédération Françaises des Services à la Personne* (FEDESAP) and the *Fédération du service aux particuliers* (FESP). Each of these organizations is a signatory to a collective agreement covering each arrangement.

In Italy, employers of domestic workers or live-in care workers began to organize in the 1960s, when the organization of domestic workers prompted members of the clergy and other human rights-oriented employers to form small associations. This led to the formation of *Nuova Collaborazione*, and in 1974 the National Federation of the Italian Clergy signed the first collective agreement covering domestic workers. Since then, the organization of employers has become much more widespread, eventually leading to the formation of two national federations of employers of domestic workers, the *Federazione Italiana Datori di Lavoro Domestico* (FIDALDO) and the *Associazione Nazionale Famiglie Datori di Lavoro Domestico* (DOMINA) (Hobden, 2015b, p. 3).¹⁸² DOMINA is an association of householders while FIDALDO is a federation of associations of householders and organizations.

¹⁸² Hobden (2015b), cited “Italy case study: new initiatives, organization forms and sources of power for articulating (collective) labour interests in the domestic work sector”, Inclusive Labour Markets, Labour Relations and Working Conditions Branch, WORKQUALITY Department (Geneva, ILO, 2015), unpublished.

In Argentina, Germany and Uruguay, pre-existing homemakers' associations, which had been founded to represent housewives' and consumers' collective interests, became the interlocutors for employers of domestic workers, in response to demands for collective bargaining with domestic workers' organizations. In Germany, the *DHB Netzwerk Haushalt* (Household Network) represents private households that employ domestic workers. The *DHB Netzwerk Haushalt* was originally founded as the Federation of German Housewives (DHB), with the primary purpose of promoting the professionalization of home economics (Basten, 2015, p. 31). While this remains its aim today, it has also become the official negotiating partner of the NGG union (which represents workers in private households) for a collective agreement in the domestic work sector.

In Uruguay, after the passage of its law on domestic workers in 2006, the *Liga de Amas de Casa, Consumidores y Usuarios de Uruguay* (LACCU) was asked by the Ministry of Labour and Social Security to represent the employers of domestic workers on the Wage Council Group 21 (*Consejos de Salarios Grupo 21*), the mechanism for negotiating sector-based minimum wages in the country. After confirming that this role was within its statutes, and after having received approval from its national assembly, the *Liga de Amas* agreed to perform the role on condition that it received technical and legal support from the Ministry. LACCU has since strengthened its position as an organization of employers of domestic workers, expanding its membership base among household-employers and improving its services to its constituency.¹⁸³

More recently, in Argentina, the *Sindicato de Amas de Casa de la República de Argentina* (SACRA) has similarly taken the role of representing private households in negotiating a collective agreement in the domestic work sector. In September 2015, it signed a historic agreement with seven domestic work unions (Hobden, 2015b, p. 7; Nugent, 2015).

Ireland does not have a specific employer organization in the domestic work sector, but the Irish Business and Employers Confederation (IBEC) participated in negotiations for a Code of Practice for Protecting Persons Employed in Other People's Homes.¹⁸⁴ Produced by the Labour Relations Commission, in conjunction with the social partners, the code of practice states that domestic workers are entitled to the employment rights and protections available to other employees and that employers are obliged to inform their employees of their rights.

5.2.4. COLLECTIVE BARGAINING

Collective bargaining helps to ensure that employment standards satisfy the interests of not only care workers, but also care recipients (who may be direct employers of care workers).¹⁸⁵ By being inclusive of all home-based care workers, collective agreements are instruments for extending protection to migrant care workers. In Italy, which heavily relies on live-in migrant care workers, the first collective agreement covering domestic and care workers was concluded in 1974 between three national trade unions, the National Federation of the Italian Clergy and Nuova Collaborazione. When employers of domestic workers also formed organizations – DOMINA in 1996 and FIDALDO in 2001 – they too became signatories to the collective agreement (Hobden, 2015b). The collective agreement, which is compulsory for employers who are members of DOMINA or FILDALDO or who have entered into contracts that explicitly or implicitly refer to it, covers wage rates, periods of rest, paid holidays, sick pay and severance pay. These conditions apply to migrant domestic workers.

¹⁸³ For more information, see <http://ligadeamasdecasa.com.uy>.

¹⁸⁴ The code of practice can be found on the Workplace Relations website: https://www.workplacerelations.ie/en/Good_Workplace_Relations/codes_practice/COP10/.

¹⁸⁵ The ILO supervisory bodies have emphasized that the right to collective bargaining as embodied in the Right to Organise and Collective Bargaining Convention, 1949 (No. 98) should be recognized for domestic workers, and covers organizations representing these workers.

In the United States, home-care workers (native-born and foreign-born) in Illinois and California, who are technically considered independent contractors, won the right to bargain directly with the state, which is considered the “employer for the purpose of bargaining”. As a result, they managed to achieve wage increases (box 5.7 and box 5.8).

Box 5.7. Collective bargaining with the state: Illinois home-care workers

In Illinois, Medicaid and Medicare are handled at the state level. The Service Employees International Union (SEIU) had a dual strategy: it worked to win recognition and to bargain with private home care agencies while it also engaged in legislative work to win the right to bargain directly with the state. In 1990, the union won the right to include an option for dues check-off, which radically increased its revenue and organizing capacity, and “meet and confer” agreements, a limited form of union recognition. Several years later, the governor established “fair share agreements” in the home care industry, requiring workers who benefited from a contract negotiated by the union to either pay dues as a union member or remain non-union and pay a “fair share fee” to the union. In 2003, the governor signed an executive order that gave home care workers the right to bargain directly with the state government, by recognizing the state as their employer for the purposes of bargaining.

As of 2013, home care workers covered by the SEIU contract were being paid \$11.65 per hour. The current contract also provides for health insurance (state payment into the union’s health benefit fund); a labour-management committee to address ongoing questions and concerns in the industry; a \$2 million annual contribution to the union’s Training Fund and a mandatory orientation programme for new home care workers; low-level health and safety protections and grievance procedures. As of 2012, the Chicago SEIU local represented 27,000 home care workers. According to the SEIU, wages for workers in Illinois increased from \$7 per hour when the union was first recognized in 2003 to \$13 per hour by the end of 2013. According to Sachs (2007), unionization enabled these workers to achieve impressive gains: home care workers in Illinois secured wage increases of 149 per cent, in California 147 per cent. Their victory benefitted native and foreign-born home care workers.

Source: Goldberg, n.d.; Hobden, 2015b; Sachs, 2007 cited by Goldberg, n.d.

5.2.5. ALLIANCE OF CARE RECIPIENTS AND THEIR FAMILIES AND CARE WORKERS

One of the messages coming out of the previous sections and the discussion above is that care workers, care recipients and their families share a common interest in the quality of care. Pressures to cut care costs have led to institutional arrangements that adversely affect not only the conditions under which care workers are employed and expected to provide care, but also the quality of care received by persons needing care. Improvements for one group cannot and should not be secured at the expense of the rights the other. The following paragraphs present three examples that illustrate this approach.

The Caring Across Generations is a US-wide campaign that brings together care recipients, unpaid family caregivers, paid caregivers and employers, and seeks a broad change in the nation’s policy and culture of care.¹⁸⁶ Its premises are: People are living longer than ever, and most older people need care. But nursing homes can be expensive and isolating, and very few want to live in one. As a result, families are very often stretched thin. The movement thus seeks change in three dimensions: (i) for everyone to have “access to affordable, quality long-term care – including the freedom to live at

¹⁸⁶ See the Caring Across Generations website at <https://caringacross.org/policy-agenda/> for more information.

home”); (ii) for families of persons in need of care to receive better support; and (iii) for professional caregivers to be able to stay on the job and take care of their own families as well. It is not yet clear what the movement has accomplished.

The second example is an initiative offset up by employers. The Hand in Hand employers’ association in the United States is a network of “employers of nannies, housecleaners and home attendants working for dignified and respectful working conditions that benefit the employer and worker alike”.¹⁸⁷ The founding employers were, and continue to be, motivated by the needs of employers, especially those who are vulnerable, such as older persons and employers who are ill or with disabilities, and by a belief in the rights of domestic workers. Hand in Hand was founded in 2010 by a group of domestic worker employers and their allies who had worked side by side with domestic workers to support the passage of the New York State Domestic Worker Bill of Rights. From a small, volunteer-led organization, Hand in Hand has grown into an organization with a staff, a strong national leadership and growing influence and reach in New York, California and beyond. Hand in Hand has worked with individual employers to develop a “code of care” that would set standards for employers of domestic workers. The association is currently testing neighbourhood-based dialogues between employers and domestic workers, with a view to establishing collective bargaining units at the neighbourhood level.

The third example is the union of home care workers (SEIU) in California, which saw the necessity of building a coalition with “consumers” of home care services (i.e. older persons and persons with disabilities) in order to improve the overall state funding for home care, the only way that their wages and care benefits would improve (box 5.8). The successes achieved by the unions of home care workers and organizations of older persons and persons with disabilities suggest that building alliances between the two parties of the care process can expand the terrain of possibilities in the domestic work sector.

Box 5.8. California: Coalition of home care workers and care recipients

In California, Medicaid and Medicare are handled at the county level, and the authority to shape the employment relationship was further delegated to the county level. In the majority of the state’s counties, care workers were classified as “independent providers” who were part of the state’s In-Home Supportive Services (IHSS) system, which is part of California’s Department of Social Services. Under the IHSS system, private employers (often referred to as “consumers” in this system) hire and supervise the home care workers, while IHSS issues pay cheques. Workers who are independent providers are considered to be “contractors”. The state’s more diffused counties tended to adopt agency contractor models, disbursing IHSS funds to for-profit or non-profit agencies, which then hire, manage and pay home care workers directly.

Early domestic worker organizing efforts in California proved that limits of state funding restricted the ability of employers to raise wages past a certain point. SEIU thus chose to adopt a political strategy to pressure county governments to increase funding for home care and to engage in bargaining directly with workers. In these efforts, it focused on organizing the independent providers who worked for IHSS, and on allying with consumers who were invested in both increasing home care funding and advancing the independent provider model (which generally provides better services and greater

¹⁸⁷ See <http://domesticemployers.org> for further details.

authority to consumers than do agency models). SEIU won some early legal victories in the 1980s, including one that held that counties and the state were responsible for wage and working hour violations, and one that argued that the fact that the state paid workers directly gave the state sufficient control to be considered an employer (Boris and Klein, 2006).

The union then turned to legislative strategies to advance its efforts to enable workers to collectively bargain with the state. It built a coalition with organizations representing older persons and persons with disabilities, who were concerned about budget cuts that could negatively impact their ability to receive the care they needed to remain in their homes. Its efforts united demands for workers' rights with campaigns to maintain and expand government funding for home care work. In 1992, the union won state-level legislation that allowed counties to establish public authorities to serve as "employers of record", which could engage in bargaining with home care workers. These authorities would be responsible for bargaining with the union, providing job training and running registries to match workers and employers. Reflecting SEIU's efforts to mutually advance the interests of workers and consumers, older persons and those with disabilities were represented on the decision-making bodies, reflecting their demands for greater voice in determining the conditions of their care and giving them a stake in assuring the success of these bodies. This victory laid the foundation for unionization in the state, giving them an employer body with which to bargain.

As of 2013, there were approximately 365,000 home care workers who were represented through unions for the purposes of collective bargaining in California. Organizations representing the interests of older persons and persons with disabilities were represented on the boards of a number of public authorities in California. The participation of organizations representing older persons and persons with disabilities was crucial to the victory of the campaigns demanding the establishment of a public authority; it gave those campaigns the moral authority and the expanded social base they needed to win.

Source: Goldberg, n.d.; Boris and Klein, 2006; Boris and Klein, 2012, cited by Goldberg, n.d.

5.3. AREAS FOR FURTHER RESEARCH AND ACTION

Based on the discussion of issues and review of actions presented in the preceding sections, a number of areas for further research and for the development of policy and practical strategies can be identified.

5.3.1. KNOWLEDGE GAPS: AREAS FOR FURTHER RESEARCH

Despite the considerable amount of research that has been conducted on migration and migrant care workers, there are still many significant knowledge gaps. The following are identified as areas for further research; the results of which would be valuable for the development of policy, law and practical strategies.

- Empirical analysis of pay differentials by gender, race/ethnicity, migrant status, care occupation, care service, location of care delivery and care sector, and factors that influence the wage penalty on care occupations.
- Determining patterns of employment and working conditions of migrant workers in educational services and organizations.

- Monitoring the implementation of bilateral agreements covering specific categories of care workers, and empirical assessment of their impacts on actual terms and conditions of employment and workers' protection.
- Empirical assessment of the outcomes of legal reforms affecting migrant workers and care workers, especially those working in private households.
- Extent to which migrant workers in formal care organizations, such as hospitals and schools, enjoy, de jure and de facto, the right to organization and collective bargaining, and the legal and non-legal factors that shape the exercise of this right.

It may be useful to set up an “observatory network” for a period of time (for example five years) with the objective of monitoring, systematically, changes in care regimes and related migration and employment regimes, and changes in actual conditions of employment of migrant and non-migrant care workers. This should help to reduce the patchiness of data on care jobs and care workers.

5.3.2. AREAS FOR DEVELOPMENT OF POLICY AND STRATEGIES

The preceding sections have identified many areas and issues requiring attention and response. The five major areas are highlighted below.

1. At the level of policy, the governance of temporary labour migration could be improved. Bilateral agreements, memoranda of understanding and standard employment contracts – the preferred instrument in many migration corridors especially between Asia and the Middle East – are largely ineffective for extending real protection of migrant workers' rights, and cannot replace legal protection. The policy and legislative regime covering employment by private households and in-home work requires particular attention in terms of analysis and development. International partners should continue to advocate for the strengthening of legal protection of migrant workers. They should also provide sustained technical assistance to key national partners (particularly governments, employers and organizations of migrant workers, care workers and domestic workers) to help them design labour legislation that provides effective protection for migrant workers and care workers who work in or for private households.
2. Migration policy regimes that apply to temporary labour migrants and low-skilled migrants require creative rethinking, given the contrasting concerns of the parties. The current policies and rules have largely been restrictive and discriminatory. They make it difficult for foreign-trained care professionals to gain formal recognition and frequently channel and trap these migrants in low-paid, precarious and vulnerable work situations, despite the real and growing demand for their services.
3. The important role of home-based care workers (many, or in some cases most, of whom are migrants) in delivering the care system should be made visible and be recognized by policy-makers and stakeholders. Policy and knowledge-sharing forums at international and subregional levels would be helpful.
4. Innovative approaches to older person care and childcare are required, given the rising care needs and costs and cuts to budgets. Budget cuts and cost-containment in older person care and childcare take their toll not only on care recipients (especially those with little or no income of their own), but also on local-level care providers and care workers (e.g. through having increased responsibilities but a lower budget or wage). Fiscal pressures tend to be pushed down to those at the lowest level, who are often a migrant care worker or home-based carer. The common interests of care recipients and care providers/care workers should be emphasized.

5. The asymmetries between countries of origin and countries of destination will hamper efforts to introduce fairer terms of migration. The supply of workers ready and willing to migrate, often despite the known risks of abuse, together with the dependence of governments on remittances and on their overseas employment strategy, swings the balance of power against migrant care workers. Competition between countries of origin for the greatest share of overseas labour markets reduces their leverage when bargaining for better wages and protection for their nationals. The situation is particularly poor for migrant domestic workers, who receive least protection in host countries. In destination countries, care workers themselves are divided and stratified according to differential rights and privileges. In this regard, strategies that strengthen the bargaining position of workers and governments of countries of origin are called for.
- Strengthen alliances and mutual support between workers and migrant organizations in origin and destination countries. Trade unions have a major role to play.
 - Strengthen cooperation between organizations of care workers across the care economy within host countries (between those in formal institutions and those in day care and home-based care; between agency-based workers and those employed by private households; between migrants and native-born care workers). They share common interests.
 - Build alliances between care workers and care recipients. They share a common interest in improving and securing the quality of care for everyone. Good practices and lessons learned in this area should be documented and shared widely.
 - Build coalitions between countries of origin. There are many attempts in this field (e.g. Colombo process, ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers and their Families), but the competition between them remains strong, constraining efforts to protect migrant workers. This probably requires coalitions of workers from across different countries of origin to exert political pressure on their governments.
 - Continue to advocate for rights of migrant workers, and organize shaming campaigns against countries (e.g. GCC countries) that are slow to extend legal protection to migrant workers within their borders.

ANNEX 1: BRAIN GAIN/BRAIN DRAIN; CARE GAIN/CARE CRISIS

Researchers have attempted to determine whether the costs arising from the migration of teachers and health-care professionals are outweighed by the benefits. Some posit that migration benefits developing countries in several ways. Migrants send money home; indeed, remittances often contribute a large share to the gross national product (GNP) of some countries. Since migrants return home with valuable skills and new knowledge acquired abroad, migration results in “brain gain” rather than “brain drain”. And, by demonstrating that more education can result in higher incomes, migration can encourage those who have remained in the country to pursue an education too. While there are no clear-cut answers, it is generally conceded that too much emigration of skilled and experienced people is harmful to the countries of origin.

The remittances that migrants send home, made possible by wage differentials between what migrants earn in their host countries and what they would have earned in their countries of origin, make migration visibly desirable. Remittances are large and growing. Compared to the early 1980s, migrants’ official remittances had grown fivefold by the early 2000s (Hermele, 2015, p. 11).¹⁸⁸ A calculation by Martin (2004, as cited by Appleton et al., 2006, p. 772) posits that unrestricted migration could more than double global GDP.¹⁸⁹ Without disputing the huge income gains that international migration brings to countries of origin, there are other aspects of the issue that have a significant impact on these countries.

This annex focuses on care issues arising from the emigration of a country’s care workers – the capacity of origin countries to care for their own citizens and residents, and the capacity of migrants’ own families left behind to care for their members. Like the other sections of this report, this annex relies on available data or estimates and studies, so faces the same major limitation, i.e. the lack of hard evidence on the scale of emigration; most countries of origin do not keep records (much less produce statistics) of how many of their citizens emigrate by profession or education. This section does not deal with the topic of remittances, except tangentially in connection with the situation of families left behind in home countries.

¹⁸⁸ Hermele noted that the total value of remittances has exceeded the volume of development aid three times over (Hermele, 2015, p. 11).

¹⁸⁹ Overseas Filipinos’ remittances contribute an average 8.5 per cent of Philippine GDP; in 2016, they amounted to \$26.9 billion.

A. BRAIN DRAIN OR BRAIN GAIN?

Available data on emigration rates of skilled workers in 2010-11 indicate that many countries, especially small states and least developed countries, were “losing” a high percentage of their tertiary-educated population to other countries. Top ten countries with the highest rates were Guyana (93 per cent), Haiti (75.1 per cent), Trinidad and Tobago (68.2 per cent), Barbados (66.2 per cent), Jamaica (48.1 per cent), Tonga (48.1 per cent), Mauritius (43.8 per cent), Zimbabwe (43.6 per cent), Congo (37.4 per cent) and Malta (36.5 per cent) (KNOMAD and World Bank Group, 2016).

Thus, the cost of losing educated and resource-rich people (as highly educated individuals often are in developing countries) has become a major concern in international and national policy circles, and a major counterargument against the benefits of migration.

REDUCED CARE CAPACITY

When large numbers of health and education workers emigrate, origin countries may end up with domestic labour shortages, and so have understaffed, overburdened schools and health-care systems. This may result in a reduction in those countries’ national capacity to address their own unmet needs, and eventually contribute to lower development outcomes and growth.

In 2006, the World Health Organization (WHO) estimated that there was a shortfall of more than 4.3 million health personnel across the world, with developing countries particularly hard hit (WHO, 2006). Virtually all of those countries were in sub-Saharan Africa. Buchan and Calman (2004, cited by Fleury, 2016, p. 20) estimated that sub-Saharan African countries had 600,000 fewer nurses than was deemed necessary to meet the Millennium Development Goals for health.

Take Malawi as an example. From 1999 to 2001, 60 per cent of registered nurses left tertiary hospitals in Malawi, probably to migrate (Martineau et al., 2001, cited by Fleury, 2016, p. 20). In 2005, 11.3 per cent of Malawian nurses were working in OECD countries (WHO, 2006). Health professionals who remained faced not only lower pay than their colleagues who had left, but also increased workloads (Martineau et al., 2004, cited by Fleury, 2016, p. 20). Some 64 per cent of positions became unfilled (no information for how long), with many medical centres operating without nurses or with employees with as little as 10 weeks’ training. The Malawian Government made efforts to increase resources and wages but it could not compete with overseas salaries.

Data from the Ghana Nurses and Midwives Council indicate that 71 per cent of nurses leaving Ghana between 2002 and 2005 went to the United Kingdom, followed by 22 per cent to the United States. The migration of nurses reached a peak in 2000, fell substantially in 2006, and has levelled off since then. Despite an increase in nurse recruitment since 2003, there were just over 22,000 nurses in Ghana in 2010, representing a ratio of just under ten nurses per 10,000 population. The PSI *Ghana national report* on women health and social care workers (Pillinger, 2011a) noted that the health-care system in Ghana faced a crisis. Nurses and health-care workers were leaving the country faster than they could be trained. Women health-care workers, and nurses in particular, were dissatisfied with their current jobs due to the lack of opportunities for professional and skills development, low staff morale and motivation, long hours and inadequate pay (Anarfi et al., 2010, cited by Pillinger, 2011a, pp. 6-7, 17).

Studies suggest that the “brain drain” has less to do with quantitative effects, and more to do with qualitative effects; for example, it is not simply the numbers of trained teachers who move that is important, but the kind of teachers who migrate (Appleton et al., 2006).

A case study on the migration of teachers from Jamaica and South Africa (mainly to the United Kingdom and United States) did not find a “major *direct* effect of international teacher recruitment in causing

harmful shortages of teachers” (Appleton et al., 2006, pp. 781–782). In both countries, the effects on schools that lost teachers were modest and any staff shortages were only temporary, and there were no knock-on effects that “impacted disproportionately on pupils from more disadvantaged backgrounds”. The main effects were qualitative, i.e. it was the better qualified, more effective teachers who were lost. Owing to the highly selective and controlled immigration policies of developed countries, it is the most experienced teachers who are most often recruited (Sharma, 2012; Ochs and Yonemura, 2012/13). Targeted recruitment of teachers usually aims to address shortages in subject areas and levels that are underserved by the destination country’s domestic teaching force. For example, there was a permanent out-migration of experienced teachers in sciences and mathematics from India, which presented a big loss to India as it already faced a shortage of teachers (Sharma, 2012).

In Kenya, between 2005 and 2010, women made up 91 per cent of those filing applications for registration to migrate. Many of them were highly skilled nurses, the majority being Registered Community Nurses, followed by Registered Midwives and Registered Nurses (Pillinger, 2011b).

Other countries have faced difficulties in filling vacancies left by the emigration of more qualified, experienced professionals. In Fiji, where teachers comprised the largest professional group of emigrants, vacancies had to be filled by less experienced and junior teachers, which led to falling educational standards (Voigt-Graf, 2003, cited by Sharma, 2012, p. 267). Rural schools found it particularly difficult to recruit and keep qualified and experienced personnel. For small island states like Jamaica, the loss of relatively large numbers of teachers can be disastrous. At one recruitment round that occurred during a school year, experienced senior teachers had to be replaced by newly qualified teachers (Sharma, 2012).

LOST SKILLS, LOST INVESTMENT

An issue related to the loss of skilled workers is the loss of investment in their education and training, and the additional cost of having to train workers to replace them. The abovementioned study of migrant Jamaican and South African teachers in England estimated the cost of migration in terms of teacher training subsidies in these origin countries (Appleton et al., 2006, pp. 872–873). Given an average loss of 17 years for Jamaican teachers and 14 years for South Africans (based on average intended stay overseas), the countries of origin would have to train, on average about one extra teacher for every two who migrate.

The investment cost of losing a trained and degree-educated nurse or nurse-midwife in Malawi was once estimated to range between \$241,508 and \$25.6 million, with bank interest rates of 7–25 per cent per year over a period of 30 years (Muula et al., 2006, as cited by Fleury, 2016, p. 20). Ghana had reportedly lost \$60 million in training its health professionals (Martineau et al., 2004, as cited by Fleury, 2016, p. 20). Since 1951, India has lost approximately \$5 billion in the training of doctors (Nayak, 1996, cited by Fleury, 2016, p. 20).

By recruiting care workers from developing countries, developed countries effectively save on human resources, development costs and time, while resource-poor countries indirectly subsidize wealthier nations through the training of health-care personnel (Fleury, 2016).

There are other sides to the issue of losing skilled people and investment. First, migrants do not always leave their country of origin permanently. Going by the predominance of temporary migration visas in developed, high-income countries, many migrants return, perhaps after a short contract, or in a periodic or “circular” pattern. However, it must be noted that the desire to secure overseas employment for an indefinite period is not uncommon among migrants. Second, staying at home may mean that the worker must accept unsuitable employment, which would also represent a loss in

investment. It cannot be assumed that all skilled migrants, before going overseas, were employed in jobs that were using their competencies properly, or that they would not be unemployed or underutilized had they not emigrated (Hermele, 2015). Finally, the remittances that migrants send home contribute significantly to family incomes and improved standards of living, much of it going to children's education and health care. A study of 33,000 migrants in 11 major destination countries showed that higher education leads to higher earnings and thus larger remittances (Bollard et al., 2011, cited by Hermele, 2015, p. 26).

Paradoxically, there are countries of origin which produce too many teachers, nurses and doctors, yet have underserved areas. For example, Nepal overproduces doctors and nurses due to the liberal distribution of licences to new education institutions, which was intended to ensure the availability of health personnel for rural areas (ILO 2017a). However, few graduates opted to serve in the rural areas and many were motivated to seek overseas jobs instead. Similarly, many Filipinos who have taken courses in nursing and caregiving did so with the aim of securing an overseas job. The Philippines, which has pursued a "labour export" strategy for decades and where having an overseas job (sometimes regardless of working conditions) has acquired a high social status, has a huge industry of recruitment agencies and training programmes oriented towards overseas labour markets.

"BRAIN GAIN", "BRAIN CIRCULATION"

Recent literature has focused on the potential for "brain gain", where countries of origin gain from the new knowledge and skills that their migrants have acquired overseas (Appleton et al., 2006). The migrant teachers from India who migrated to the United Kingdom and United States (Sharma, 2012) and participants in teacher exchange programmes in France, Spain and the United States (Caravatti et al., 2014) highlight the developmental and enriching experience of migration. It is partly in this light that the merits of temporary migration and circular migration have been cited – these migration models ensure that migrants return home after a definite period or periodically within an established time frame, thus meeting the needs of destination countries while promoting "brain gain" or "brain circulation" and minimizing "brain drain" for the countries of origin (McLoughlin and Münz, 2011; Hugo, 2013). However, despite these advantages, circular migration programmes might have negative implications for workers' rights (Castles and Ozkul, 2014 Wickramasekara, 2011). These are discussed further in the next section.

At the moment, however, there are not enough data to show the extent to which new knowledge and skills have been gained, shared with and benefitted countries of origin, or among which categories of migrant workers, countries of destination and origin, and under what conditions such gains have been realized. The country of destination, specific migration programme and status, employment contract, occupation and sector, and/or racial and ethnic identity, among other factors, may have a bearing on a migrant's professional development opportunities and experiences, and on their decision to stay or return.

RISKS OF DE-SKILLING MIGRANTS

There are situations where migrant care workers enhance their skills and bring back new capacities to their home countries. But in some cases, care professionals also lose their skills in destination countries (IOM, 2012; Cometto et al., 2013). The OECD's 2007 outlook on migration observed that regardless of the definition used and the country in question, immigrants were more likely than the native-born to hold jobs for which they are over-qualified (OECD, 2007a, pp. 131–159). In all the countries considered, "at least 25 per cent, and on average nearly 50 per cent, of skilled immigrants

between 15 and 64 years of age were inactive, unemployed or relegated to jobs for which they are over-qualified” (OECD, 2007a, pp. 149–150).

A striking finding from the OECD report is that foreign-born women seemed to be at an even greater disadvantage than foreign-born men. This may be traced to a number of gender biases: sex-based job segregation, hierarchical bias against women, pay penalty and gendered bias in definition of skills assessment. In New Zealand, female migrants from China and India were more likely to have higher degrees and certifications than the national average, yet they were more likely to be unemployed or paid lower wages (Ghosh, 2009 cited by Fleury, 2006, p. 24). Similarly, about 70 per cent of Peruvian domestic workers in Chile were found to have completed high school or university (Ortega, 2001, cited by Fleury, 2006, p. 24). The same 2007 OECD report pointed to the role of recognition of diplomas and qualifications, as well as employers’ information about education acquired abroad.

B. CARE CRISIS?

Another concern regarding migration is its impact on the well-being of families left behind by migrant workers, particularly where the migrant is a parent or principal caregiver of the family. Citing various studies, Fleury (2012, p. 19) notes the strain on families and the disruptive effects on child development caused by separation or by changes in parenting or shifts in household and childcare responsibilities.¹⁹⁰ For example, the absence of a mother has been associated with a greater likelihood of children receiving less schooling, of adolescents being involved in risky behaviour and of children displaying violent or unlawful conduct. A study of high-emigration communities within Mexico suggests that households in which respondents have a spouse who was a caregiver and who migrated to the United States are more likely to have at least one child with academic, behavioural or emotional problems than non-migrant households (Lahaie et al., 2009; Heymann et al., 2009). However, other research findings indicate that there is no difference in psychological or familial problems for children with migrant parents. Research on the Philippines, Indonesia and Thailand finds that children with migrant parents are no different from their peers with respect to social anxiety, loneliness, relationships, psychological issues, premarital sex or smoking and alcohol use (Fleury, 2012).¹⁹¹ These contrasting findings indicate that other factors are at play, not simply the absence of a parent or the mother.

Migration has made transnational families a global phenomenon. Defined by Bryceson and Vuorela as families whose members “live some or most of the time separated from each other, yet hold together and create something that can be seen as a feeling of collective welfare and unity, namely ‘familyhood’, even across national borders”, these families demand new ways of caregiving within families (Bryceson and Vuorela, 2002, p. 3, cited by ACP Observatory on Migration, 2012, p. 6). The huge numbers of women migrating on their own for employment (largely due to demand for

¹⁹⁰ Fleury cited, among others, Petrozziello, A. 2013. *Gender on the move: Working on the migration–development nexus from a gender perspective* (Santo Domingo, Dominican Republic, UN Women); Mitrani, V. B.; Santisteban, D. A.; Muir, A. 2004. “Addressing immigration-related separations in Hispanic families with a behaviour-problem adolescent” in *American Journal of Orthopsychiatry* Vol. 74, No. 3, pp. 219–29; King, R.; Vullnetari, J. 2006. “Orphan pensioners and migrating grandparents: The impact of mass migration on older people in rural Albania” in *Ageing and Society*, Vol. 26, No. 5, pp. 783–816; UNICEF-Moldova. 2006. *Remittances and migration in the Republic of Moldova*. Working Paper (Moldova); Hanson, G. H.; Woodruff, C. 2003. *Emigration and educational attainment in Mexico* (San Diego, University of California); and D’Emilio, A. L.; Cordero, B.; Bainvel, B.; Skoog, C.; Comini, D.; Gough, J.; Dias, M.; Saab, R.; Kilbane, T. 2007. *The impact of international migration: Children left behind in selected countries of Latin America and the Caribbean* (New York, UNICEF).

¹⁹¹ Fleury cited: Scalibrini Migration Center. 2004. *Hearts apart: Migration in the eyes of Filipino children* (Manila); Battistella; Conaco. 1998. “Impact of labor migration on the children left behind: A study of elementary school children in the Philippines” in *Sojourn*, Vol. 13, No. 2, pp. 220–241; Choe et al. 2004. “Substance use and premarital sex among adolescents in Indonesia, Nepal, the Philippines, and Thailand” in *Asia-Pacific Population Journal*, Vol. 19, No. 1, pp. 5–26.

their care labour) mean that many of these families have been “left behind” by their (traditionally) principal caregivers: mothers, wives and daughters. Transnational families imply transnational parenting, transnational childrearing or transnational care – strategies of childcare, older person care and spouse care that cross national borders (Peng and Wong, 2016). Initial studies show the dynamics and challenges involved, as mothers as well as fathers craft ways of continuing their roles, albeit in new circumstances, and the complexity and diversity of caregiving and care-sharing strategies (Peng and Wong, 2016). What is emerging is that transnational strategies reflect gendered ideologies and practices of childcare and caregiving within the family, while also challenging the traditional gendered labour division of care between fathers and mothers, men and women. Some studies, such as Parreñas (2010, cited by Peng and Wong, 2016, p. 2024), maintain that women’s international migration and increased breadwinning power have not resulted in significant changes in the gendered labour division of parenting. Grandmothers, daughters and other female relatives are roped in to provide immediate childcare while the involvement of “left-behind” husbands in childcare remains limited or sporadic. Left-behind husbands are often unwilling to take care of children because doing so would run against or threaten their traditional views of fatherhood and masculinity. On the other hand, there are studies that show increasing involvement by men in childcare, as both migrant fathers and left-behind fathers (studies cited by Peng and Wong, 2016).¹⁹² Migrant women have thus demonstrated agency in renegotiating and reinterpreting their care roles and care-sharing responsibilities with their husbands/partners, while men have shown capacities to adjust to new parenting roles. There are many possible social impacts of transnational parenting and caregiving, but transnational families and their implications for care and social policies are under-researched despite being a global phenomenon (ACP Observatory on Migration, 2012, p. 18).

¹⁹² Peng and Wong (2016) cited: Hoang; Yeoh, 2011. “Breadwinning wives and ‘left-behind’ husbands: Men and masculinities in the Vietnamese transnational family”, in *Gender and Society*, Vol. 25, pp. 717–739; Nobles. 2011. “Parenting from abroad: Migration, nonresident father involvement, and children’s education in Mexico” in *Journal of Marriage and Family*, Vol. 73, pp. 729–746; and Waters. 2010. “Becoming a father, missing a wife: Chinese transnational families and the male experience of lone parenting in Canada”, in *Population, Space and Place*, Vol. 16, No. 1, pp. 63–74.

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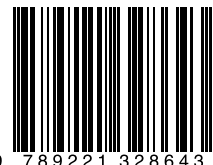
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