

# **Regulating Migrants as a Low-Cost Solution for Long-Term Care: The Formalisation of a Dual Care Labour Market in Austria**

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**Abstract:** *This paper explores how care, migration and employment policies in Austria shaped the long-term care labour market and how the legalisation of ‘24-hour care’ by migrant carers contributed to dual labour market structures. It offers important insights into the Austrian approach of subsidizing demand for home care services that relies on low-cost employment of migrants to meet current care needs. The authors conclude that the migrant care policies were unable to address persisting inconsistencies at the interface between the primary and grey care labour market. Instead, they fostered the dualisation of the care workforce which is characterised by double standards that divides carers by migration and nationality, socio-economic differences, precarious working conditions, social protection entitlements and labour rights.*

## **Key words:**

Migrant carers; 24-hour care; dualisation; regulation; grey labour market; long-term care.

**Zusammenfassung:** *In diesem Artikel wird untersucht, wie politische Maßnahmen in den Bereichen Pflege, Migration und Beschäftigung zu einer Restrukturierung des Arbeitsmarktes im Bereich der Langzeitpflege beigetragen haben, und wie die Legalisierung der (vorwiegend migrantischen) ‚24-Stunden-Betreuung‘ die Schaffung dualer Strukturen am Arbeitsmarkt verstärkt hat. Der österreichische Ansatz wird dabei beleuchtet, der durch die Bereitstellung von Geldleistungen die Nachfrage nach Pflege- und Betreuungsdiensten erhöht, diese aber zugleich nur durch die Beschäftigung von migrantischen Pflegekräften auf Low-Cost-Basis erfüllt. Die AutorInnen kommen zu dem Schluss, dass die Maßnahmen im Bereich der migrantischen Pflege bereits bestehende Unterschiede zwischen dem ‚primären‘ und dem ‚grauen‘ Arbeitsmarkt im Bereich der Pflege nicht kompensieren konnten. Stattdessen kommt es zu einer (weiteren) Stratifikation der Beschäftigten im Pflegesektor. Diese basiert insbesondere auf einer Trennung nach Migrationshintergrund und Nationalität der Pflegekräfte, nach sozioökonomischen Unterschieden, Grad der Prekarität der Arbeitsbedingungen, sowie nach sozialversicherungs- und arbeitsrechtlichen Ansprüchen.*

## **Schlüsselwörter:**

Migrantische Pflege, 24-Stunden-Betreuung, duale Strukturen, Regulierung, grauer Arbeitsmarkt, Langzeitpflege

## **Introduction**

This chapter deals with various aspects and consequences of a gradual regulation of labour in the area of domestic and care services over recent years in Austria. While this development shows some similarities to other coordinated market economies in Europe, it also reveals specific features that may be explained by a particular Austrian pathway to construct ‘functional equivalents’ to family care in the context of a ‘conservative’ welfare regime.

Similarly to France and Belgium, Austria introduced a voucher system called service cheques (*Dienstleistungsscheck*) in 2006 that enables families and individuals to purchase domestic services<sup>1</sup> (Shire, 2015), as well as a tax credit for families for childcare services that are provided by persons with a minimum qualification (BMASK, 2014). Yet the most striking specificity of the Austrian way of dealing with domestic services and care for older people lies in its extensive use of migrant care workers.

This specificity is partly rooted in the general characteristics of Austrian long-term care policies over the past two decades, and in its proximity to neighbouring countries with lower wages and high unemployment. First of all, in 1993, Austria introduced a universal long-term care allowance to compensate dependent persons for individual care-related expenditures. This tax-funded cash benefit is not means-tested and not ring-fenced and is granted according to needs in seven levels to all citizens needing more than 60 hours of care per month. The flat-rate amounts of the allowance range between €154 and €1,656 per month. On average, beneficiaries are paid about €500, which may be used according to the beneficiary’s needs and preferences. Secondly, while the scheme increased purchasing power of people with long-term care needs, the scheme’s introduction coincided with a gradual opening of borders to neighbouring Eastern European countries. This, in turn, has led to the development of new types of care arrangements, namely the hiring of personal carers from these countries by private households. These so-called 24-hour carers<sup>2</sup> live in the same household with the person in need of care to carry out all types of assistance with activities of daily living, but also with personal care, in general replacing an informal (family) carer (Procházková et al., 2008). Generally, one household hires two personal carers, as each of them is staying for biweekly shifts before being replaced by a colleague. In the 1990s, such arrangements had spread across the whole country as illegal work arrangements. Hence, in 2007–2008, the Austrian government was the first in Europe to attempt a regulation of personal care in terms of labour and tax legislation, professional regulations and social security.

In order to ensure legal employment of 24-hour carers in private households and to avoid a (further) loss in social security contributions and tax payments, the ‘Personal Care Act’<sup>3</sup> – based on an ancient law for maids and

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butlers – was introduced and the Code of Trade and Commerce was amended in 2007. Both regulations created a legal basis for the 24-hour care arrangements with the following options for hiring a 24-hour carer:

- The first option is direct employment of 24-hour carers by care organisations or by families who pay social contributions and income taxes. Apart from minimum wages and leave entitlements, this arrangement includes working time regulations that stipulate a maximum working time of 11 hours per day and 128 hours during a biweekly shift ([BGBl. I Nr. 33/2007](#)).
- The second option, which has been chosen by the large majority of 24-hour carers, is self-employment. This arrangement allows for more flexible, actually unregulated working times, does not consider minimum wage rates specified by trade unions, and offers relatively straightforward registration procedures (WKÖ, 2014; Bachinger, 2010).

In the first case, social security contributions and taxes are due to be paid by both employers and employees, while in the second case, these are to be paid by the self-employed carers only. As these additional payments have increased the costs of hiring 24-hour carers significantly, legislators also introduced special subsidies to incentivise regular arrangements. These subsidies for employers were aligned with the Austrian long-term care allowance scheme.<sup>4</sup> In order for the public subsidy to be paid, the law stipulates qualification requirements. In addition, a number of other criteria have been specified to become eligible for the subsidy, including the fact that a separate room must be available for the carer in the household. In practice, this means that many families are unable to host a 24-hour carer in their home, and the scheme is mainly attractive for middle-class families (see also Schmidt et al., 2014).

In sum, policies to regulate domestic care services enable a certain group of beneficiaries to legally rely on 24-hour care that is very similar to the previously illegal arrangements, with part of the additional costs being reimbursed by the public subsidy. In practice, this means that many 24-hour carers are faced with more legal protection, yet paradoxically also with under-regulated work arrangements where they bear all the risks of self-employment, analogous to small enterprises operating in Austria. The situation is compounded by the fact that domestic services by definition are strongly characterised by personal relationships, and dependence on other stakeholders. While the legalisation in 2007–2008 contributed to consistently carve out the hitherto black market of 24-hour care, regulations of working conditions remain highly precarious and fail to meet general labour standards (e.g., concerning working time or social security, in particular for the large majority of self-employed 24-hour carers). In addition, to accelerate the employability of self-employed 24-hour carers, a simplified registration procedure with the Austrian Economic Chambers was created that automatically reports 24-hour carers to social security institutions.

These new regulations, in combination with existing long-term care policies, have created a new area of domestic care services with important consequences for the labour market, thus increasing the gender and ethnic divide in the care sector.

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The Austrian care market is thus an interesting case in the context of the political economy of domestic services and the process of state-driven strategies throughout Europe to boost employment in domestic services as a panacea for solving challenges related to the cost of care, increasing female labour market participation and reconciling domestic tasks with market work (see also Beneria, 2007). Both intended and unintended consequences of related endeavours in Austria have certainly contributed to a dualisation of its labour market, in particular in the area of long-term care. Surprisingly, there has been only limited analysis on how recent policies that subsidize and structure demand for domestic care work have shaped the labour market in Austria.

In this chapter, we analyse the imbalances that these policies have created in the Austrian labour market for care professionals. In particular, we contrast regulations regarding entry into the 24-hour care market with those concerning entry into the mainstream long-term care sector.<sup>5</sup> We argue that the Austrian care labour market is characterised by a double standard with regard to skill requirements, labour rights and social status. Based on empirical evidence from qualitative interviews, we first seek to understand whether the policy changes of 2007–2008 have contributed to bridging the cleavages between the – formerly irregular – 24-hour care market and the market of mainstream long-term care services. We then compare the differences in access opportunities of care professionals from Germany, an EU country with similar wage levels to Austria, to those of carers working in the 24-hour care sector, mostly from Eastern European countries characterised by lower wage levels than Austria. Based on this analysis, we try to shed light on the underlying rationales that have led to the current policy arrangements. It is argued that Austria provides a showcase of how labour market, migration and care policies intersect and shape double standards in the care labour market in terms of professional standards, social protection and working conditions.

The analysis will be based on dual labour market theory and concepts that describe interactions between dual labour markets, migration and conditions of work (Piore, 1979; Redfoot and Houser, 2005). The outline of our approach is followed by a brief description of the dual labour market in long-term care in Austria, and further exemplified by an analysis of the distinct labour market hierarchies of foreign care professionals in Austria. In total, 23 qualitative interviews were conducted with 8 German long-term care professionals, 9 24-hour migrant carers from Slovakia, Romania and Hungary as well as with 6 public officials working with one of the two migrant groups. The German care professionals and 24-hour carers were identified through opportunistic sampling, while we aimed for maximum variation with regard to their origin, professional background and experience. Public officials provided contacts to potential interview partners using methods of purposive snowball sampling. Different interview guidelines were used depending on the professional situation and experiences of each stakeholder group. Questions for care professionals with German training covered their motivations for migration, registration and recognition procedures in

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Austria, as well as the differences in qualifications and responsibilities in their current professional status in Austria.

Migrant carers were asked about the registration process as 24-hour carers as of 2007, comparing the situation before and after registration and the implications of the reforms for their professional status in Austria.

In the final section, we discuss the findings in the context of increasing demand for long-term care professionals and outline perspectives for improved integration of the currently segmented labour markets in the provision of long-term care in Austria.

## **Health and social care as dualised labour markets**

A dualised labour market is defined as one that is ‘divided into two main segments with limited mobility between them’ (Marx, 2012). These segments constitute a primary and secondary labour market that can be distinguished in terms of job security, duration of employment, level of compensation, likelihood of receiving on-the-job training and other features of working conditions. This phenomenon of dual or segmented labour markets can be observed not only in individual countries or companies, but also within individual sectors of the labour market. Among these, migrant workers are overrepresented in jobs with unpleasant working conditions and low social status, including lack of job security, unstructured work environments as well as informal, highly personalised work relationships (Doeringer and Piore, 1971; Piore, 1979).

The characteristics of dual labour markets also apply to the sector in which personal care is provided in general. In fact, a specific hierarchy is often observed between different types of care services. The main distinction can be made between acute health care (funded by the health care system) which tends to be better paid and comes with higher qualification of staff, and institutional and community care (as part of the social care system), being characterised by lower pay and limited qualification requirements. Social care provision thus comes with lower status, payment and fewer career opportunities, which is why professions in this sector, and especially in domestic care, attract only a few native workers, and are thus often taken up by migrant carers (Redfoot and Houser, 2005: 7ff; Polverini and Lamura, 2004).

Still, even *within* the social care sector, a further segmentation can be observed along gender and ethnic divides. The lower the level in the organisational hierarchy and the lower the required educational level, the more staff will be female and/or of non-native origin. Migrant carers therefore often find themselves in precarious employment with low wages and poor working conditions including long working hours, ‘more night shifts than their native peers’ (van Hooren, 2012: 133), and less flexible working times (Näre, 2013: 616). Also, the closer personal care enters the ‘life-world’ of recipients, and the distinction between formal and informal caring tasks becomes blurred, the less

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regulated organisation of care work tends to be, and the more caregivers tend to be, again, female and of foreign origin.

This situation has several negative consequences to be borne almost exclusively by individual migrant care workers. Firstly, as ‘self-employed’ personal carers, they are inclined to accept difficult working conditions, such as long working hours, night and holiday shifts; this is aggravated by the fact that they are heavily dependent – in particular with respect to the continuity of job allocation – on brokering agencies to which at times they even have to pay fees. Secondly, as self-employed carers, they accept lower wages due to their weakened negotiating power. Thirdly, even though they often possess higher skills than local workers in host countries, they are subject to a lower social position, as their skills may not be recognized (*cf.* Wako, 2012 for Japan). The specific developments shaping these intersecting ‘dualised’ labour market structures in Austria will be described in the following section.

## **Dual labour markets as a result of long-term care policies: The case of Austria**

Austria was one of the first countries that responded to increasing care needs by the introduction of cash benefits that aimed to strengthen autonomy and choice of users, who could decide whether to purchase residential care or home care services, or to compensate informal carers (Leichsenring et al., 2013). Such schemes fit also with the EU’s concern for promoting policies to stimulate demand for ‘personal and household services’ by introducing cash benefits, vouchers or tax reductions (Morel, 2015). With the policy rhetoric of ‘out-patient before in-patient care’ the scheme also aimed to strengthen traditional family care and to promote informal support at home (Österle, 2013: 167). At the same time, the supply of both home care and residential care was incentivised, too, yet not growing homogeneously across all regions, and not sufficiently to cover existing demand for more services. The home care sector of the Austrian long-term care market thus turned into a demand-driven market in which the preferred type of care services could be purchased with public subsidies (Hofmarcher, 2013: 199ff.; Evers et al., 1994).

The improved purchasing power of beneficiaries and the vicinity of low-wage countries triggered care arrangements in which families privately hire personal carers, also called ‘migrant carers’, as they are predominantly middle-aged women from Eastern European countries. These forms of employment initially came with no regulations on working time, no social security coverage and a generally irregular labour market status. After a heated public debate in 2006, the status of so-called 24-hour care was formalised in 2007–2008 by regulations on qualification requirements of carers, working-time and social security. However, the formalisation process remained patchy: in particular, to qualify as a personal carer requires no more than 200 hours of training, evidence of six months of practical experience or a medical doctor or a nurse taking the responsibility to delegate clearly defined nursing tasks to



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the 24-hour carer (BMASK, 2008; BPGG §21b; Procházková et al., 2008: 169f.). Qualification requirements only apply if the care recipient applies for a 24-hour care subsidy. Otherwise, a 24-hour carer can be hired privately at any time without any further requirements regarding previous training or experience.

The working schedules most commonly practised by 24-hour carers in Austria are biweekly shifts that are usually organised by agencies that also ensure replacement in case a carer falls out. In fact, agencies play a crucial role in facilitating the implementation of the 24-hour care arrangements, having large influence on wages provided to carers and quality standards practiced (Schmidt et al., 2013). While working time regulations during these biweekly shifts differ for employed and self-employed personal carers, working hours are often heavily influenced by the health status, personality and living situation of the older person in need of care. That is, many self-employed 24-hour carers have to stay on call-duty for 24-hours a day to assist the person in need of care. Under the new formalised scheme, self-employed carers thus continue to work under precarious conditions as inspections in private households are legally ruled out.<sup>6</sup>

Foreign care professionals have also long represented an important share of the labour force in Austria's mainstream health and care sector. The 2004 EU enlargement led to an additional increase in the share of foreign-born nurses from EU-10 countries to Austria, which by 2006 accounted for almost 38% of all foreign-born nurses (Wismar et al., 2011: 97). Recent data indicate a further increase in the shares of non-Austrian employees in the mainstream care sector between 2008 and 2011, rising by 13.6% in hospitals, 51.5% in nursing homes, and 28.5% in social and home care for older people.<sup>7</sup> In other words, nurses and carers from low-wage Eastern European countries not only work in the 24-hour care sector, but also in the mainstream care sector, facilitated by the free movement of labour across EU borders. Notwithstanding the importance of care professionals from Eastern European countries, the largest group of foreign care professionals working in the mainstream care sector comes from Germany. In 2011, German care professionals were working mainly in the Austrian hospital sector (Lenhart and Österle, 2007; AMS, 2012).

In general, German care professionals do not face many barriers to migration, given the cultural and linguistic proximity to Austria as well as similar education and long-term care settings. Based on long-standing bilateral agreements, German nurses are recognised as equivalent to Austrian nurses in their job profile.

When comparing labour market structures in the mainstream care sector to those in the 24-hour care sector, differences are striking. The legal regulation of 24-hour care facilitated the employment of personal carers or 'self-employed' personal carers.<sup>8</sup> The vast majority of 24-hour carers, however, opted for self-employment, as this offers more flexibility concerning working time, workload and salary, entails a lower bureaucratic burden for families and is

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mostly the only option offered by brokering agencies. Table 8.1 shows the number of self-employed 24-hour carers, of which 94% are women, who are registered with the Austrian Economic Chambers as active or inactive (i.e., dormant self-employed activity). In 2013, about 43,000 active self-employed 24-hour carers were contracted by at least 21,000 families with a person in need of care.<sup>9</sup>

There is high fluctuation for many 24-hour carers who perceive this activity as a temporary occupation, or hope to be able to become employed in the primary health and care labour market in Austria or in their country of origin later. However, recognition of diplomas can be more difficult for nurses from Eastern European countries, compared to nurses from Germany, and depends on the professional activity and year in which the diploma was obtained. For instance, Slovak nurses that graduated before 2004 need to prove that they worked as a nurse for at least three years within the last five years. Further, they are required to provide work references as well as documents issued by the Ministry of Health that prove their qualification and authorisation as nurse. Although recognition is regulated by law, in reality, the process for Slovak nurses is still more complicated compared to that for German nurses (BMG, 2014). In fact, nurses from Slovakia and Romania are more often required to accomplish training or to pass a qualifying exam in order to be recognized as nurse in Austria (BMG, 2012).<sup>10</sup> However, in a recent study at one of Austria's largest home care providers, which also acts as a brokering agency, a large number of 24-hour carers expressed their desire to work in the mainstream care sector in Austria in the future (Pfandl, 2013).<sup>11</sup>

Table 1 Number of self-employed 24-hour carers in Austria by registration status and region (July 2013)

	Burgen - land	Carinthia	Lower Austria	Upper Austria	Salzburg	Styria	Tyrol	Vorarl- berg	Vienn a	Austria
Active	2,357	2,198	11,927	7,328	1,356	6,475	1,869	2,103	7,546	43,159
Inactive <sup>12</sup>	1,982	1,038	3,939	1,388	612	2,136	543	382	1,493	13,513
Unsubscribe d <sup>13</sup>	3,807	2,534	11,612	7,886	2,190	6,899	2,391	1,681	7,470	46,467

*Source:* Data provided by the Austrian Economic Chambers and from Hilfswerk Austria, 2013.

In short, the 24-hour and mainstream care sectors are structured in highly different ways in terms of their labour market regulations. Firstly, the formerly irregular 24-hour care sector is still characterised by much longer working shifts (during the 14-days care period each month) than the mainstream care sector, high fluctuation of staff, and few possibilities for vocational training. This situation might be partly attributed to a lack of possibilities to unionise for workers in the domestic sphere, on the one hand, and to monitor working conditions, on the other, especially when working for private employers or being dependent on middlemen, as is commonly found in 'informal economies'



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(Beckert and Wehinger, 2013). Secondly, the dualised structure of the care labour market reflects contradictions in EU policies as well as at the national level. While a lack of qualified care personnel with specific skills in order to ensure quality is acknowledged, domestic service policies are aimed towards creating employment for low-skilled workers in the care sector (Morel, 2015). In the Austrian case, the employment of low-qualified and low-paid self-employed 24-hour carers in private households was actively promoted, legalised and simplified with the formalisation in 2007, while it remained a relatively tedious procedure for care professionals from EU countries to access the primary care labour market.

## **The experience of migrant carers in dual labour markets: Professional standards, working conditions and social protection**

In this section, we describe the experiences of foreign professionals in dual labour markets of long-term care, namely of German care professionals working in the primary labour market and 24-hour carers from Slovakia (the latter representing nearly 80% of all 24-hour carers in Austria (ÖGKV, 2008)), with a focus on professional standards, wages, social protection and working conditions.

### **Professional standards: access, qualification and responsibilities**

While professional standards and access to the primary health and care labour market are strictly regulated by the Health and Nursing Act, qualification requirements for 24-hour carers were newly defined, and existing regulations were amended. For instance, apart from support with activities of daily living, ‘nursing tasks’ such as medication or subcutaneous injections may also be carried out if delegated by a medical doctor or a nurse. Paradoxically, these tasks may not even be carried out by the bulk of professional social carers with much higher qualifications. In practice, many personal 24-hour carers provide similar services as nurses, which creates an ambivalent situation, with overregulation of care diplomas on the one hand and under-regulation of qualification requirements on the other.

Overall, the mainstream care sector remains a relatively closed market, which is hard to access for foreign care professionals. For example, German geriatric nurses are not recognized in Austria despite the fact that their qualifications are at least equal to that of nurses because elements of social care prevail in their training (BMG, 2009). The non-transferability of the German diploma also holds for the profession of a geriatric nursing auxiliary (*Altenhelferin*), with one year of training.

In stark contrast, 24-hour carers without specialised training in care face low qualification requirements. Literally any person, regardless of professional background, may qualify as a personal carer by taking a basic 200 hours of training, which is equivalent to the theoretical training as a home helper, the lowest qualification in the

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mainstream care sector. To make things worse, if the family is not entitled to a public subsidy for 24-hour care, no qualification requirements exist for 24-hour carers at all. Training does not include any medical skills, knowledge about special diseases or medication needed when providing care for frail older persons. Nevertheless, about 20% of 24-hour carers working in Austria are experienced nurses in their country of origin (Hilfswerk Austria, 2013). One of the nurses interviewed clearly stated that the qualification requirements for 24-hour carers are by far not sufficient when caring for persons with specific chronic diseases or disorders (e.g., dementia, epilepsy, stroke, or MS, etc.), in particular when it comes to critical situations:<sup>14</sup>

From what you learn in the 200-hours training you do not know much; you do not have experience in a hospital. Once, when I worked in Upper Austria, the old man fell out of his wheelchair and collapsed.

Immediately, I laid him down, put the feet up and started a cardiac massage and rescue breathing. After ten minutes, his heart started to beat again. At the hospital, the physician told me that he had a severe epileptic disorder. . . . But imagine a personal carer who does not know what to do. The patient would simply die.

(Personal carer, 49 years old, qualified as a registered nurse from Slovakia)

In addition to nursing skills, language skills are also an important precondition for personal care. Though most brokering agencies of 24-hour carers conduct language tests in order to ensure communication between carer and client, no standardised procedure for language certification exists. There are also no regulations for quality assurance or accreditation of these brokering agencies operating in Austria and in neighbouring countries (Österle et al., 2012; Schmidt et al., 2013).

## Wages and social protection

Once they have passed the often-cumbersome recognition process in Austria, carers and nurses from Germany (or other EU countries) have social security entitlements equal to Austrian citizens given employment with a care home or another recognised care provider. These issues are somewhat more complicated for 24-hour carers from Slovakia (or other EU countries), as they are predominantly self-employed. This means that they are, for instance, not entitled to minimum wages or unemployment insurance. It is usually up to the brokering agencies to find a new placement for the personal carer who is thus dependent on them, under pressure to accept even difficult working situations, and may have to pay (also undefined) contributions for this service (Bachinger, 2010). Furthermore, personal carers registered as self-employed in Austria have to pay social security contributions for pensions, work injury and health care, even if they are still covered by their home country's health insurance. While employers of personal carers are entitled to a means-tested subsidy to pay for additional expenditures, namely the employer's social security contributions, self-employed 24-hour carers are entitled to a reduction in contributions only during their first three years of activity, as

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they are officially considered ‘young entrepreneurs’.<sup>15</sup> Apart from rising contributions after three years, often combined with a lack of adequate information on that increase, self-employed 24-hour carers are generally disadvantaged as they only have an income replacement in case of illness after 6 weeks of invalidity for a duration of 20 weeks. Further, they do not receive continued payment of remuneration during vacation.

The transformation of formerly undeclared personal care work into a ‘legalised’ activity in private households had only a relatively small impact on wages for 24-hour carers. As the regulation of 24-hour care did not stipulate a minimum wage for self-employed 24-hour carers, wages are generally set by the agencies according to the carer’s qualification and the care recipient’s health status. Thus the daily wage for self-employed carers usually ranges between €50–70 per day for 14 days per month.<sup>16</sup> Deducting the monthly social contributions from these daily wages, self-employed 24-hour carers are left with a monthly salary of between €543 and €823, from which some income tax still remains to be deducted.<sup>17</sup> The monthly net wage for employed 24-hour carers that is defined by the collective minimum wage agreement for employees in households was equal to about €1,130 in 2013. Although it has to be considered that the employer is obliged to provide board and lodging, and theoretically to also pay for transportation, the monthly wage of employed and self-employed 24-hour carers remains far below the monthly gross wage for full-time employed home helpers working in the mainstream care sector, which amounts to €1,647 per month.<sup>18</sup> This cleavage in remuneration becomes even more contradictory in light of longer working hours and the around-the-clock availability in 24-hour care. According to a 39-year-old certified physiotherapist from Slovakia, who was working as a registered 24-hour carer, ‘If you receive 800 EUR per month, and every three months you have to pay 800 to 900 EUR [for social insurance], plus the rent and travel costs that I have to pay ... not much money is left for me at the end of the month. It is terrible.’

Finally, the wages of 24-hour carers are affected by the fact that travel time is usually not considered to be working time.

It should be mentioned that the accession of Bulgaria and Romania as new member states, has triggered a new pricing competition, resulting in daily wages for carers even below €40. This ‘race to the bottom’ is attributable mainly to the lack of quality monitoring on behalf of public authorities in the 24-hour care sector, which has led to competition through prices rather than through quality standards (Schmidt et al., 2013). While migrant carers working in the mainstream care sector are completely integrated into the Austrian wage-system, based on collective bargaining, as well as into respective social security provisions, these issues remain to be further elaborated for so-called ‘self-employed’ personal carers. Due to their specific status, working time regimes and the often temporary activity of 24-

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hour care, migrant personal carers from Slovakia or other countries need special attention, at both the national and

European levels, to overcome the precarious characteristics of their situation.

## Working conditions

The main motivation to come to Austria for many geriatric nurses from Germany is the high level of stress and intolerable working conditions in German care homes, stipulated in particular by the intense quality assurance regulations that absorb a substantial amount of working time, impeding many carers from finding the appropriate time to devote to residents. Less stressful working conditions in Austrian care homes motivate geriatric nurses to cross the border, even accepting that they cannot fully exercise their profession. As employed professionals in care homes or home care, their weekly working time does not exceed 38 hours, and they are entitled to 30 days of paid vacation each year (Sozialwirtschaft, 2013: 8).

For employed 24-hour carers, the newly introduced law regulates working time, stipulating that carers must not work more than 128 hours during a shift of 14 consecutive days. They have to respect a compulsory break of 3 hours per day during work and a 10-hour break within 24 hours. Following a 14-day shift, they need to rest for the next two weeks. In theory, they thus remain within a calculated average of about 9 hours working time per day. While it remains difficult to control compliance with this rule for employed 24-hour carers, working times of their self-employed colleagues are not regulated at all. Even if they usually also follow the schedule of biweekly shifts, their working time and amount of work depends on the level of care needed. Interviews revealed that many carers exceed a daily working time of 11 hours per day during their two weeks shift in a month:

You need to observe everything. During the night, I often go into his room to look if he is still breathing, and I have to change the diaper. . . . Last year, his mother was still alive, and I was able to take one hour off per day. Now this is not possible anymore, but that doesn't matter because I have a mobile phone, and I can talk with my friends via phone in the evening. (Certified physiotherapist from Slovakia, 39 years old, working as registered 24-hour carer)

Also, the work itself is challenging for many 24-hour carers because they cannot rely on any assistance by colleagues or family members in their daily caring tasks. A certified nurse from Slovakia, age 32, noted, 'In one family, difficulties arose because the patient was much taller and 40 kg heavier than me. Therefore several carers have had problems'.

The results of this study show that working conditions as well as wage levels differ significantly between 24-hour carers and care professionals in the mainstream sector. Nonetheless, the results also indicate that both migrant

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care groups are satisfied with the working conditions in Austria. German geriatric nurses seem to be relieved to have more time to dedicate to care recipients. For 24-hour carers, the close and trusting relationship with the patient, and being able to concentrate on one person's needs, seems to be a positive asset, as is the possibility of returning to their home countries on a biweekly basis. Notwithstanding the relatively low wages, the positive effects of the reform are acknowledged, too: '(However,) for me this [type of legal arrangement] is very good, because my papers and my registration are in order. . . . I definitely do not forget the day on which I registered' (Certified physiotherapist from Slovakia, 39 years old, working as registered 24-hour carer).

## Persistent dualised structures of the labour market in long-term care

This study has addressed the increasing challenges in the area of employment, migration and long-term care within and between EU member states, as summarised in Table 2.

Table 2 Key dimensions of the dual labour market in long-term care in Austria

Dimension	Migrant carers working in the mainstream long-term care sector (e.g., from Germany)	24-hour carers working in private households (e.g., from Slovakia)
<i>Status in labour market</i>	Formal employment contracts Acknowledgement of existing skills and training following official recognition process (EU directive 2005/36/EC)	Mainly self-employed Registration with the Austrian Economic Chambers
<i>Wages and social security</i>	<ul style="list-style-type: none"> <li>⌘ Wages based on collective bargaining</li> <li>⌘ Social security contributions shared between employee and employer</li> <li>⌘ Direct contact with employers</li> </ul>	<ul style="list-style-type: none"> <li>⌘ Wages based on market prices set by competing brokering agencies</li> <li>⌘ No unemployment insurance (if self-employed)</li> <li>⌘ Social insurance contributions from employees only (if self-employed)</li> <li>⌘ Dependency on agencies</li> </ul>
<i>Hierarchy of skills and training</i>	<ul style="list-style-type: none"> <li>⌘ Defined hierarchy between registered nurses, nursing assistants, geriatric nurses, social carers (with impact on wages and competencies)</li> </ul>	<ul style="list-style-type: none"> <li>⌘ Low threshold of training requirements (formal training and skills do not impact on status or payment)</li> </ul>
<i>Working conditions</i>	<ul style="list-style-type: none"> <li>⌘ Highly regulated, strong presence of trade unions</li> <li>⌘ Night-shifts for residential care only</li> </ul>	<ul style="list-style-type: none"> <li>⌘ Fortnightly shifts with max. 11 hours per day (24-hours stand-by) for employed carers.</li> <li>⌘ No working time restrictions for</li> </ul>

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self-employed 24-hour carers.

On the one hand, the analysis shows that the endeavours by the Austrian government to formalise the status of previously undeclared personal carers have been partly successful. In particular, migrant workers in the 24-hour care sector are now granted social protection and health insurance. On the other hand, paradoxically, the creation of this new segment has widened cleavages in the care sector. The mainstream care sector is shown to be a relatively closed market in which recognition of formal skills is hampered by the lack of harmonised procedures for different EU member states and qualification levels. The 24-hour care sector is characterised by minimum regulations regarding qualification and monitoring, and even if a number of 24-hour carers are highly skilled, general standards remain poorly defined. While the Austrian health care sector is already highly segregated from the social care sector, with the latter being associated with lower qualification, status and payment, the creation of the 24-hour care sector as a distinct arrangement for the provision of long-term care has added a new (lower hierarchical) segment, increasing cleavages in the sector even further.

In sum, the legal amendments linked to the regulation of ‘24-hour care’ reveal a number of unsolved problems and contradictions at the interfaces – and ‘grey’ areas – between the mainstream (social) care sector and the 24-hour care sector, but also between health and social care, and between EU member states. The non-recognition of German geriatric nurses with, at the same time, ample leeway for self-employed ‘personal carers’ is only one example of inconsistencies due to existing hierarchies, contradicting policy aims and corporate strategies. It is legitimate to assume that one source of such inconsistencies stems from the fact that personal care, both in its regulated and unregulated characteristics, has remained a female activity as part of reproduction work.

Given existing barriers in accessing the mainstream care sector, particularly female carers from low-wage Eastern European countries are overrepresented in jobs with low social prestige, low salary and labour rights (unemployment benefit, paid vacation and sickness leaves etc.) and are thus still trapped in precarious working situations. By living and working in the households of frail older clients, 24-hour carers work in highly personal and informal relationships that are not subject to labour inspections and face unstructured work schedules. The 24-hour care reform has vaguely defined a professional profile for 24-hour carers in the Code of Trade and Commerce, thus raising their professional status, yet the job remains unattractive for Austrians as well for migrants and care professionals from EU countries with similar wage levels to Austria’s.

Nonetheless, 24-hour care is perceived as a win-win situation by the general public, public authorities, and 24-hour carers themselves. As a functional equivalent to family care, it fits in well with the Austrian family-based care



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regime. With the combined use of long-term care allowances and public subsidies, 24-hour care is an affordable alternative. More than two thirds of the around 21,000 families that make use of such arrangements are eligible for the public subsidy (Schmidt et al., 2014), which certainly reveals the popularity of this scheme. This is also attributable to the absence of affordable alternatives for care at home for more than 2-3 hours of home care per day. However, it must be mentioned that these arrangements remain a privilege being mainly used by middle- and upper-class families with appropriate housing conditions to host a 24-hour carer (Schmidt et al., 2014).

As an income opportunity, 24-hour care in Austria also helps women from low-wage countries into gainful employment on a legal basis, while at least partly maintaining their lives in their home countries, as they do not need to move to their workplace permanently. Indeed, unemployment in workers' home countries (i.e., 14.8% in Slovakia in 2013) and higher wages in Austria are still the main drivers to move into 24-hour care. The difference in wages is particularly significant for health and care professionals, with graduate nurses working in the health system in Slovakia, earning an average net wage of about €556.<sup>19</sup> High unemployment rates in their home countries, one-to-one care relationships and the possibility to return home on a regular basis for 14 days make 24-hour care still attractive for Slovak women, in particular for those without any qualification, even under conditions of dependency on brokering agencies and very weak bargaining power concerning wages.

If compared to other EU member states, in most of which no regulation nor integration of 24-hour care has been implemented (Lamura, 2013), Austria has certainly searched to strike a balance between over- and under-regulating migration and employment of foreign care workers. However, no strategy has been found yet to overcome the divided structure of the labour market in long-term care. Similar to the other countries reviewed in this volume, employment policies of the 24-hour care scheme in Austria actively promote employment of low-skilled workers and migrants in domestic and care services. However, by doing so, they also actively deregulate the labour market for specific target groups. Certain rights have been granted to 24-hour carers (i.e., social and health insurance), yet labour market regulations (e.g., working times, sickness benefits) are less strictly monitored. Policymakers are hesitant to further regulation, since the current 24-hour care model, which offers flexible and exclusive one-to-one care, would otherwise not be feasible and would incur much higher costs. This also corresponds to the interests of a large group of people with long-term care needs who prefer live-in 24-hour carers, who represent 'more value for the money' rather than mainstream home care or a transfer to residential care.

The labour market is thus divided by nationality, socioeconomic differences, precarious working conditions, social protection entitlements and labour rights (Williams, 2012; Morel, 2015) as a result of both labour-market

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policies and current long-term care policies in Austria. The latter create a dualisation of the workforce by setting a legal framework that keeps low-skilled unorganised migrant domestic carers in the secondary labour market and maintains hierarchies within the care workforce in terms of skills, remuneration and precarious working conditions. Furthermore, within the mainly 'female' sector of care work, an additional dualisation has been created between more-regulated and less-regulated care sectors. Hence, by strengthening user choice through cash-benefits and public subsidies for private care, the classic pattern of segregated labour markets has been reproduced, in particular within the sector of private care.

The success of the 24-hour model that was fostered by the combination of cash-benefits and public subsidies becomes evident in the steep rise of 24-hour carers since its legalisation in 2007–2008. By 2013, the number of registered and active 24-hour carers reached 43,159. Compared to the 14,618 employees<sup>20</sup> in the mainstream home care sector, 24-hour carers clearly represent a relevant source to increase the available workforce in both low- skilled and highly skilled segments of health and social care services (Lamura, 2013: 307; OECD, 2011; Bachinger, 2010). However, no clear strategy that integrates migrant 24-hour carers in the mainstream care sector can be perceived in Austria, despite a large proportion of current 24-hour carers conceiving their activity as a first step towards employment in formal home care services, care homes or hospitals in Austria (Pfandl, 2013: 59). Yet, policymakers and families currently see the reliance on 24-hour migrant carers mainly as an affordable alternative to reduce expenditures for formal long-term care services and facilities.

Integration of 24-hour care into other areas of the care sector, as well as into active labour market policies, and thus a stronger regulation of working conditions and respective minimum labour standards, would be necessary to overcome dual labour markets and staff shortages. A small-scale initiative by the Ministry of Internal Affairs and welfare organisations, which aims to enhance the integration of migrants in the mainstream care sector by providing support to meet language and pre-qualification requirements, has recently been started and has shown some success (Medienservice Stelle, 2013). However, actual numbers of 24-hour carers who successfully move into the mainstream sector are scarce. It remains to be seen whether large-scale proactive policies will develop to facilitate such processes. From a midterm perspective, it might well be that an important source for additional workforce in the mainstream care sector will wither away, if the expectations of 24-hour carers to join the primary (care) labour market in Austria are not taken seriously, and dualised labour market structures will persist.

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1 The present research was carried out in the context of the FP7 Framework Project 'European Care Across Borders' (ECAB, Grant agreement no. 242058). Actually, the 'service cheque' in Austria has suffered from very low take-up rates since its introduction in 2005. By 2007, only about 2,700 users used these cheques to buy on average services for about €100 per month (Korunka et al., 2007).

2 The terms 24-hour carers, migrant carers and personal carers are used interchangeably in the text. 24-hour carers are defined as privately paid personal assistants, with or without training, living in the private household of older people and/or their families to support them with activities of daily living and personal care.

3 The literal translation of the act entitled 'Hausbetreuungsgesetz' (BGBl. I Nr. 33/2007) would be the 'Home Care' or 'Home Assistance' Act. As this would insinuate mainstream home care, we decided to use 'Personal Care Act' in the English translation.

4 The public subsidy for 24-hour care is granted only to people in need of at least 120 hours of care per month (at least care level 3 of the long-term care allowance scheme, except in cases of dementia, where a lower threshold can be agreed upon), and to people with a personal income of less than €2,500 per month. The monthly subsidy amounts to €1,100 for two employed 24-hour carers (€550 for one) and €550 for two self-employed 24-hour carers (€275 for one).

5 In the mainstream health and long-term care sector, regular care services are provided by carers and care professionals who are, in theory, employed by institutions (i.e., home care agencies, care homes or hospitals).

6 The Federal Social Welfare Office carries out 1,000 to 2,200 quality visits to randomly selected recipients of the 24-hour care subsidy each year. However, the main focus of these visits is the care situation, rather than the working conditions of personal carers (Schmidt et al., 2013; Procházková et al., 2008).

7 Calculations are based on data provided by the Austrian Public Employment Service (AMS), dating from June 2012.

8 The relevant Personal Care Act also stipulates formal employment of any family member, thus blurring the boundaries between formal and informal care even more. In reality, however, this solution has rarely been adopted.

9 This is due to the fact that generally two 24-hours carers cover one client with fortnightly shifts, respectively.

10 For example, only 9 (out of 770) German nurses that requested recognition in 2010 were required to pass the qualifying exam or to do a training whereas 28 (out of 222) Slovakian nurses and 25 (out of 63) Romanian nurses that requested recognition were required to pass the test or the training (BMG, 2012).

11 In detail, when asked about their future employment perspectives, 24-hour carers (N=593) cooperating with a large non-profit provider of home care in Austria, 56.7% of (multiple) answers were 'to work in the home care sector', 13.1% 'to work in a care home' and 3.3% 'to work in a hospital'. 16.1% of answers were 'to work in another sector in Austria', and only 10.8% of all answers were 'to move back home' (Pfandl, 2013: 59).

12 Inactive carers declared their self-employed activity dormant with the Austrian Economic Chambers, implying the end of the compulsory social insurance and a reduction by half of the annual contribution to the Austrian Economic Chambers that ranges between €40 and €108, depending on the federal state.

13 Unsubscribed 24-hours carers refer to those who have resigned the permission to exercise their profession of personal care and do no longer work as 24-hour carers.

14 All quotes from the interviews are own translations from German into English.

15 According to the Austrian Chamber of Labour, in 2013, social insurance contributions amounted to a lump sum of €157.3 per month during the first three years, €196.34 thereafter.

16 We consider a 14-day shift, as this is the most common practice. However, in theory, self-employed carers can work more than 14 days in a row in a private household. This is not the case for employed 24-hour carers.

17 Calculations based on guideline for 24-hours carers developed by the Austrian Economic Chambers, available at [http://portal.wko.at/wk/format\\_detail.wk?AngID=1&StID=377055&DstID=338](http://portal.wko.at/wk/format_detail.wk?AngID=1&StID=377055&DstID=338).

18 Calculations are based on collective wage agreements for the health and social sector (BAGS) for 2013: <http://www.bags-kv.at/1001,3490,0,2.html>.

19 The Austrian gross wage relates to that of a nurse in the first two years and is based on collective wage agreements for the health and social sector (BGAS) in 2008. The average gross wage for nurses in Slovakia relates to the year 2008 (Kahancova, 2013).

20 14,618 employees are full-time equivalents (FTE) working in outpatient care services, semi-inpatient care services, short-term care and alternative living arrangements in Austria in 2012 ([http://www.statistik.at/web\\_en/statistics/social\\_statistics/social\\_benefits\\_at\\_laender\\_level/care\\_services/index.html](http://www.statistik.at/web_en/statistics/social_statistics/social_benefits_at_laender_level/care_services/index.html)).