



RE M I N D E R

ROLE OF EUROPEAN MOBILITY AND ITS IMPACTS
IN NARRATIVES, DEBATES AND EU REFORMS

The Perceived Impacts of Care Mobility on Sending Countries and Institutional Responses: Healthcare, Long-term Care and Education in Romania and Slovakia

WORKING PAPER

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Abstract

Wealthier Western European countries employ care workers from Eastern European countries to satisfy the increasing need for care of their ageing populations. As European citizens enjoy the right to move and work in other European countries, so do care workers. Previous research covers, to a great extent, the effects of care migration on the mobile caregivers and their families. Less is known about the ways in which sending states respond to care-driven mobility.

This paper examines the perceived impacts of care work mobility and institutional responses in Romania and Slovakia in three particular areas: healthcare, long-term care and education. Romania and Slovakia, large suppliers to Western European countries of carers for the elderly, are the two most common countries of origin among 24-hour personal carers in Austria. To better understand the effects of care mobility on these two sending countries, the case of Austria, as a receiving country for both Romanians and Slovaks, was considered.

The results show that various stakeholders perceive care mobility to affect care-related areas in sending countries in different ways, ranging from labour force shortages, to quality of service provision, to the wellbeing of migrant family members. The main relevant issue for sending countries is that it is mostly women who engage in this type of work, many of whom leave their homes and families in order to work abroad. Migrant domestic workers, who have been supplementing low-paid care work in the private household sphere and in publicly and privately funded services, have been estimated at 11.5 million across the world in 2015, with 73.4 per cent being women (Galotti 2015). Both Romania and Slovakia have employed limited measures to address the consequences of care mobility on workers' families. On the one hand, institutions report a certain awareness with regard to care mobility, but do not consider its effects a priority; therefore, public policies in both countries have generally not responded directly to care mobility in the areas of education, health, and long-term care. On the other hand, the need for an institutional response addressing the abusive practices of actors involved in transnational job procurement towards caregivers increases, and few changes have emerged.



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1 Introduction

As Europe ages, demand for care work increases. According to Eurostat, the share of people aged 65 or over in EU28 – 19.4 per cent of estimated 511.5 million in the beginning of 2017 – has increased in the last decade by 2.4 percentage points (Eurostat 2018c). Population ageing – along with increased participation of women in the labour market, economic differences between the countries, diminishing state provision of care services, and the restructuring of the welfare state policies – is one of the main causes of an increasing need for care work in the EU. Total public expenditure on long-term care as a percentage of GDP in EU27, on average, was 1.8 per cent in 2010 (Council of the European Union 2014). Projections of public expenditure on long-term care as a proportion of GDP indicate an average 129 per cent increase across the EU27 for the period 2007–2060. Care work provided by migrants, most commonly with limited or no professional education or experience in care-related areas, has become indispensable for long-term care systems in Western European countries, and there is evidence that the share of migrant workers in this area will increase in the near future (Cangiano 2014; van Hooren 2014). Women make up about 80 per cent of the labour force in informal elderly home care (A. Anderson 2012). As they often leave their family dependants in countries of origin in order to engage in care work abroad, mobility has a range of gender-specific effects on countries of origin, such as “care drain” and a “care deficit” (Degiuli 2016; Lutz 2011; Lutz and Palenga-Möllenberg 2012).

The role of transnational caregivers in Europe’s long-term care systems has already been examined from different perspectives, ranging from the restructuring reforms of the European long-term care systems (A. Anderson 2012) to the role of welfare states and existing cash-for-care schemes (Erel 2012; León 2014; Williams 2011). Increasing care mobility¹ has also turned into a significant phenomenon from the perspective of sending countries – the ever-growing outflow of care migrants or commuters also affects countries of origin. These effects of care-work mobility were examined by prior studies mainly from

¹ In line with the UN definition of migration, which is a change in a person’s place of residence for at least three months (UN 1998), the chapter distinguishes mobility – which implies fewer than three months’ stay abroad – from migration.



the perspective of workers and their families. Previous research looked at the social implications of this outflow of care workers, such as the reorganisation of informal care obligations within families (Bauer and Österle 2016; Sekulová 2013a), or reforming gender roles through the migration process (Kuchyňková and Ezzeddine 2015). At the same time, the ways in which countries of origin respond through public policies to the care shortages resulting from this mobility (Lutz and Palenga-Möllennebeck 2012) is not covered sufficiently by previous research.

Care mobility contributes to a wide range of effects within different institutional areas in countries of origin, including health and social care – where labour shortages and the change in quality of service provision are commonly visible (Prescott and Nichter 2014) – as well as in education systems, where the migration of one or both parents affects their children. In particular, less is known in the European context about the extent to which institutions in sending countries respond to the effects of care mobility, and to what degree care mobility is a policy concern at the administrative and policy-making level.

The present paper is set to bridge this gap. It is part of a larger study aimed at exploring key under-researched aspects of the social and economic impacts of emigration on Eastern European sending countries². In particular, the study analyses the implications of intra-EU care-work mobility for sending countries, the consequences of mobility and commuting on border regions, and the impacts of return migration.

The main objective of the paper is to map the perceived effects of care mobility and the institutional responses and policy developments in three particular areas: healthcare, long-term care and education. These areas have been chosen as they have the potential to curb social inequalities both between EU countries and within a country, and to improve quality of life (Allmendinger and von den Driesch 2014). In addition to life expectancy, for instance, the *healthy* life years one is expected to enjoy are also relevant. While differences in life

² See the description in WP6 of the REMINDER project: <https://www.reminder-project.eu/publications/work-packages/wp6-countries-of-origin/>.

expectancy reach 11 years between some European countries,³ differences in *healthy* life years can reach 20 years.⁴ This, in turn, impacts on long-term care needs, which are expected to grow in the next five decades as the number of Europeans over the age of 80 is predicted to triple (Council of the European Union 2014: 3). Long-term care (LTC) entails “a range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care” (Council of the European Union 2014: 11). As the demographic development of both old and new EU member-states is characterised by an ageing population, the sustainable organisation of long-term care is a challenge for both. Education is also a policy area with major social implications, as differences in education levels have also been linked with inequalities in terms of health and life expectancy, with the less-educated being more likely to have poor health (OECD 2017: 19). These areas correspond to some of the 20 key principles of the European Pillar of Social Rights,⁵ a package of policies supported by the European Commission in order to deliver new and more effective rights for its citizens. This paper focuses on Slovakia and Romania, which both are important source countries for transnational caregivers – either migrants or cross-national circular commuters – moving into long-term home care, predominantly but not exclusively in Austria. Austria represents a specific context of care work mobility due to the principle of free movement, diverse and often temporal character of the care mobility (in the form of commuting), and formally-guaranteed labour and social rights for carers. Moreover, care-related mobility and its impact on sending countries is shaped by country-specific factors and institutional settings; therefore, the impacts have to be analysed in particular contexts. By presenting the perspectives of two sending countries – Romania and Slovakia – in connection with one receiving country – Austria – this paper contributes to policy debates relevant to the European Pillar of Social Rights.

³ According to Eurostat, in 2015, the lowest life expectancy for men in the EU-28 was recorded in Lithuania (69.2 years) and the highest in Sweden (80.4). Life expectancy for women ranged from 78.2 years in Bulgaria to 85.8 years in Spain (Eurostat 2018b).

⁴ The corresponding range for healthy life years at birth for women was between 54.1 years in Latvia and 74.6 years in Malta (a range of 20.5 years), while that for men was between 51.8 years in Latvia and 74 years in Sweden (a range of 22.2 years) (Eurostat 2018a).

⁵ For the 20 principles of the European Pillar of Social Rights, see: https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en.



The institutional reflection of care mobility in origin countries and the specific situation of caregivers (from Romania and Slovakia) are closely connected with their position as self-employed carers within the home personal-care system in Austria, including the organisation of mobility patterns, and the migration-industry actors involved and their practices. We concentrate our focus on this particular cross-national variation of transnational care-giving practice as, for a full understanding of the complexity of migration effects on sending countries, the receiving countries and the particular ways in which they are connected to the origin countries must be taken into account (Solari 2010). Thus, the paper analyses the effects of the particular care mobility patterns of non-professional caregivers from Romania and Slovakia who are self-employed in 24-hour personal home-care for the elderly and disabled in Austria.

The paper unfolds into four main sections. The first section (numbering starts with 2, following this introductory chapter) describes the cross-national variation of care mobility, based on our empirical research in Romania, Slovakia and Austria. In addition to background information on care mobility between these countries, the section describes current challenges with regard to employment conditions in the care-work sector in Europe. The second section describes the methodology employed, while the third analyses the perceived impacts of care mobility in education, healthcare and long-term care in sending countries. For each policy area, the institutional responses to these impacts are discussed. The final section summarises the main concluding points with regard to the perceived impacts of care mobility in sending countries and policy developments in the three selected areas, and underlines the relevance of care mobility at the European level.

2 Romania – Slovakia – Austria: cross-national variations in care mobility

2.1 *Care workers from Romania and Slovakia*

Care workers from Romania and Slovakia hold EU citizenship status and enjoy the right to move to other EU countries for the purpose of gainful work, be it in employment or in self-employment in a contractual relationship. In both these sending countries, economic



deprivation and the relatively large wage differences from those in destination countries drive care mobility. Care mobility from Romania and Slovakia share some features, but display differences as well. Both countries are currently a source of care-givers for Western European countries (Österle and Bauer 2012; Winkelmann, Schmidt, and Leichsenring 2015). Migrants and commuters follow certain traditional trajectories and have particular geographical ties. Romanian care migration is more diverse in terms of the destination countries (in addition to Italy,⁶ Romanian care-givers work in other European countries such as Spain, Germany and Austria), and in terms of the length of the shifts or the migration time-span. Slovak care-givers are present in other German-speaking countries (Germany and Switzerland) as well, but the spatial proximity and opportunities for rotational migration/mobility on a bi-weekly basis makes Austria the preferred option (Bahna 2014). The care mobility from Slovakia is a relatively homogenous stream directed mainly towards Austria in a dominant mobility pattern of fortnightly cross-border commuting. Slovak carers are almost exclusively circular migrants who have no desire to settle in the destination country. In addition, while Slovak carers prefer 24-hour live-in home care, Romanians work in live-out arrangements as well, with care responsibilities in more families.

Romania and Slovakia are the two most-represented nationalities in the Austrian 24-hour personal care system. At the end of 2017, the Austrian Chamber of Commerce (*Wirtschaftskammer Österreich*, later referred as WKO) registered 62,670 active self-employment licences for 24-hour personal care provision, out of which 42.4 per cent (26,144 licences) were registered by Romanians, followed by Slovak care-givers with 24,585 licences (39.2 per cent). Other nationalities such as Hungarians, Austrians, Czechs or Poles registered 11,469 licences, or 18.4 per cent of the total number (WKO 2018). However, the proportion of the different nationalities has been changing. The total number of active care-givers from Slovakia peaked recently at 26,144 in 2016, growing from 25,038 in 2013, before declining again to 24,585 in 2017 (WKO 2018). Slovak care-givers working mainly in bi-weekly shifts have dominated the 24-hour personal care sector for the last two decades. However, working as a 24-hour home personal carer in Austria became less attractive for

⁶ According to the Italian Statistical Institute, there are officially over 1.1 million Romanians in the country, more than 650,000 of whom are women and more than 80 per cent of whom are employed as care workers. However, unofficial estimates argue that the actual number of Romanian immigrants in Italy exceeds three million (Șerban 2017).



Slovaks due to a number of factors: the improvement of the economic situation in Slovakia, the high costs of care work in Austria (physical, psychological and also social, due to the carer being absent from her family), specific vulnerabilities stemming from self-employment and decreasing net wages. In contrast, care-work mobility from Romania continues to develop faster. The total number of Romanian care-givers increased from 13,065 in 2013 to 24,220 in 2016. At the end of 2017 there were 26,616 Romanians holding an active 24-hour care-giver licence (WKO 2018).

2.2 The organisation of personal home care in Austria

In Austria, there are several models for care for the elderly. Residential care (also referred to as *inpatient care*) is organised in nursing homes and homes for the elderly operated by different owners, including churches, welfare associations, humanitarian organisations, municipal or provincial governments, or private companies. *Inpatient care*, which requires the consent of the patient, is funded by the provincial governments. Patients have to contribute to the costs of inpatient care with approx. 65 – 75 per cent of their income. The operator of the nursing home also will receive the care-subsidy from the cash-for-care scheme (*Pflegegeld*), applicable according to the care-level of the patient.⁷

Mobile care is provided by private companies, welfare associations, NGOs and municipalities (BMASK 2016), as is semi-mobile care. In both cases, care-givers employed by one of the organisations mentioned are regularly visiting the client for one or more hours a day and provide care in the household of the client, or the client is cared for in a day-care facility. In these cases, the client pays the respective fees to the organisation. Depending on the care-level, the client is entitled to the respective care-subsidy from the cash-for-care scheme.

The third element of the Austrian long-term care-system is the provision of 24-hour personal care (Riedel and Kraus 2010; Österle 2013; Bauer, Haidinger, and Österle 2014). The 24-hour care system is a combination of traditional family-oriented care and the

⁷ The cash-for-care allowance is granted across seven levels (level one is for those in need of personal care above 65 hours per month, or above 50 hours per month prior to 2011, while level seven is equivalent to a monthly care requirement of over 180 hours). For the levels of care allowances see: <https://www.help.gv.at/Portal.Node/hlpd/public/content/36/Seite.360516.html>.



universal cash-for-care scheme (Österle 2013; Winkelmann, Schmidt, and Leichsenring 2015).

The provision of 24-hour care in private homes is funded from the federal cash-for-care scheme (*Pflegegeld*) and additional benefits. This cash allowance is not means-tested, and is aimed at covering the costs of care. The main purpose of the cash allowance is to support care provided by family, enabling older and disabled persons to stay at home instead of relying on institutional services. There are no restrictions on how the cash allowance is spent; the form of spending is entirely up to the recipient – whether on home adaptation, buying professional care from for-profit organisations, paying family members, or hiring private care workers, and there is no requirement for the training of the care-givers. For 2017, the lump sum ranges between €157.30 and €1,688.90 per month, depending on the monthly amount of hours needed for care and the degree of disability of the patient, which is defined in seven care-levels. With the exception of asylum-seekers waiting for the decision of their case, all persons living in Austria legally and in need of care are entitled to this subsidy.

In order to foster the employment of qualified care-givers, a further 24-hour care subsidy can be granted to persons classified at least at care-level 3 and in 24-hour care of trained care-givers (at least at the level of a trained nursing assistant⁸). For care work under an employment contract (the rare exception⁹), the additional subsidy amounts to €550 per month (up to maximum of €1,100 for households employing two carers), or to €275 for hiring a trade license carer (or €550 for two carers), whose social security contributions are lower than those of a carer under an employment contract (BMASK 2016). There are additional criteria according to which eligibility is appraised such as the income level of applicants and minimum training requirements for carers and care arrangements (carers must complete minimum training, legally hired etc.) (*Ibid.*).

⁸ This provision can be omitted if the care giver has professionally cared for the patient for already at least 6 months.

⁹ Most care workers work as self-employed (see clarifications below).



This subsidy is means-tested and only paid to persons with a monthly gross income of less than €2,500, 14 times a year. In 2016, the median gross old age pension was €1,270, 14 times a year.¹⁰

Daily 24-hour care delivered by care-givers mainly from the neighbouring new EU-Member States was common already before 2007, usually as irregular employment. The debate on the situation in 24-hour care gained momentum in 2006, when it became known that the mother-in-law of the then Federal Chancellor Wolfgang Schüssel (ÖVP) had been cared for by irregularly employed care-givers, while he was publicly denying the need for regulation of 24-hour home care (Schwaiger 2017). Following the debate, in 2007 a new legislation was passed defining two legal options for 24-hour care – standard employment and self-employment – where the latter covers about 99 per cent of all 24-hour care work arrangements (Österle and Bauer 2016).

Under the self-employment model, care arrangements for 24-hour care on average cost between €2,000 and 4,000 monthly, with some 40-50 per cent covered by the federal cash-for-care scheme and subsidies, while the rest is paid by families. Although in Austria there are institutionalized care services provided by the federal government, municipalities and other public actors (Riedel and Kraus, 2010), the 24-hour care model offers more marketable care options for the home environment and, with cash-for-care contributions, is a cost-effective and inexpensive solution to the care needs, at least for middle and upper income families. The provision of 24-hour personal care in private households is a growing sector dominated by migrants from other EU countries, mainly from Slovakia and Romania. Typical for 24-hour care in private homes is the live-in model and a rotational system of sharing jobs – each carer works in shifts of two (Slovakia) to four (Romania) weeks (Bauer and Österle 2016a).

On one hand, self-employment is a cheaper option for households and offers easier access to the labour market for carers. On the other hand, it excludes carers from the *de facto* protection which employees have in the mainstream sector of social services and health working on the basis of standard employment. Austrian labour law includes limits on

¹⁰ See Table 3.23 from the Statistisches Handbuch der Österreichischen Sozialversicherung (Hauptverband der österreichischen Sozialversicherungsträger 2017).



working time, collectively bargained wages, guaranteed social security and rights such as entitlement to annual leave, and unemployment insurance (unless care workers actively opt into a voluntary system of unemployment insurance) (Bachinger 2010; Winkelmann, Schmidt, and Leichsenring 2015). Moreover, precarious labour conditions may result from care work organisation as self-employment. Caregivers as entrepreneurs are responsible for a negotiation of the labour conditions, workload or wages¹¹. If the caregiver utilizes the services of recruiting agencies, they play a substantial role in defining these conditions. A large body of scholarship demonstrates aspects of precarity in 24-hour care-work in private homes, such as limited access to personal free time, exploitative situations, workload exceeding tasks defined by the law or exceeding the competencies of 24-hour carers, etc. (Bachinger 2010; Gendera 2010; Winkelmann, Schmidt and Leichsenring 2015; Österle and Bauer 2016).

The last year saw two main changes with regard to the provision of care in Austria. Self-employed care workers, among other working categories, are eligible for child benefits. The coalition government proposed the indexation of child benefits according to the country of residence. Many women from Eastern European countries (including Romania and Slovakia), working in care in Austria, in a rotational system, have families and dependent children in their respective countries of origin. The indexation translates into reduced child benefits as of 2019. The reform was criticised based on the current European legislation, particularly with regard to EU Regulation 884/2004 on the coordination of social security systems (DEMOS 2018).

Another relevant debate, although not directly linked with 24-hour care in private homes, is relevant for the development of the Austrian long-term care system. While the cash-for-care allowance (*Pflegegeld*) is covered from the federal budget, the federal provinces (*Bundesländer*) are in charge of organising long-term services and social assistance. The Austrian Parliament voted for a constitutional provision amending the recourse to the assets of people living in *inpatient* facilities providing long-term care (*Pflegeregress*) (Fink 2018). Before this change (implemented as of 1 January 2018), financial assets (particularly savings or real estate) of people in need of inpatient long-term care were to be utilised

¹¹ The average gross wage for demanding 24-hour shifts is low (ranging between € 50-70 per day and € 700-1,000 per month for a 14 days period) (compare Bahna, 2011c; Winkelmann *et al.*, 2015).

before the social assistance provider stepped in to cover costs not covered by other individual financial resources (*Ibid.*). As this is no longer possible, the federal government will transfer a total of up to EUR 340 million each year to federal provinces to cover the losses for social assistance. Several federal provinces responded that the amount would be insufficient to cover the costs for inpatient long-term care (ORF 22.05.2018). As *inpatient*-care is now fully funded by public resources and the contributions from the patients' income, but 24-hour care still needs subsidies by the family of some €1,000 to €1,500 monthly, some experts expect a rise in demand for *inpatient* care (*Ibid.*). Nevertheless, 24-hour personal care in private homes will continue to also increase due to the demographic developments (Kleine Zeitung 11.05.2018).

2.3 *The role of intermediaries*

The procurement of care is organized across a system of intermediaries such as recruitment and placement agencies in both countries of origin and Austria, commercial agencies, but also via social networks and informal personal networks (Gendera 2010; Österle and Bauer 2016). The extensive network of different service providers exists on both sides, sending countries and receiving countries. For instance, an increasing demand for home care led to an establishment of more than 800 recruiting agencies active in Austria in the field of 24-hour personal care up to April 2018 (WKO 2018)¹². Although the extent of the services differ, the placing agencies most commonly offer job opportunities and help caregivers to find families in need of care work, organize travel or support caregivers with certain administrative tasks (establishing trade license, etc.) for a fee, and often also organize trainings and language courses. In addition to being registered as care-givers (registered self-employed activity), care-givers can hold recruiting agencies licenses which allow them to provide both services in Austria – personal care, and recruitment of colleagues for personal care. Although a certain share of caregivers search for jobs independently, the recruiting agencies play a crucial role in job procurement between Romania and Slovakia on one side and Austria on the other. For instance, the majority of caregivers from Slovakia

¹² For details on actual number of recruiting agencies see register of Austrian Chamber of Commerce: <http://www.daheimbetreut.at/de/firmen-a-z>. Caregivers themselves register many of these agencies. In these cases, caregivers took licenses of providers as well, which allows them to recruit colleagues for the second shift, and makes them independent from placing agencies.



utilize the services of placing agencies (44 per cent) or cooperate with informal intermediaries (13 per cent), while one third searches for job on the base of personal social networks and only a negligible share of caregivers search for jobs independently (Bahna 2016). At the same time, the practises of the placing agencies are subject of criticism from actors from both sides – sending and receiving countries. Among the main subjects for criticism are high payments for services charged by the agencies, low payments for a day of care work, unsatisfactory services, lack of assistance with the contractual relation between the care giver and the family, forced travelling or unprofessional communication, to name a few (Sekulová 2013a; Gendera 2010). Lack of regulations of recruiting agencies on the Austrian side, where only a registration fee and a clear criminal record are required to obtain a license, contributes to problematic situations.

Recruitment agencies, in addition to acting as intermediaries between the carer and the person cared for/Austrian families in need of care, take on the role of negotiating care workers' fees and supporting them with their taxes and social-security contributions. Some of the Romanian care workers interviewed for this research reported abusive practices by agencies – practices such as charging the workers recruitment fees as well as charging the cared person/Austrian family who applies for a care worker, declaring but not following through with support from social security contributions, contracts available only in the language of the country of work and not in the native language of the care worker, etc.

On the other hand, the activities of recruitment agencies and other transnational actors such as government agencies, private international companies, transnational recruiting or employment agencies, nursing education institutions, private exam preparation services, licensure and exam agencies, trade unions, transnational NGOs, transnational families (Prescott & Nichter, 2014, p. 121) shape caregivers' labour conditions (through setting contract mediation and setting wages), enable access to the 24-hour personal home care market in Austria, or influence the position of the caregivers within the families and the private households, as some agencies and service providers also provide basic training. The training providers may also influence the knowledge base among carers about legal aspects of care work in Austria (which seems to be missing in practice, as interviews with a public and private service providers indicate). Furthermore, caregivers are often constrained by



the placing agency to utilize the transport organized by the same agency. Personal transport via cars below 3.5 tonnes is currently not regulated at European Union level. Drivers are therefore not obliged to rest regularly, and there are no technical facilities prescribed for the recording of driving time and driving speed as for buses or trucks (Michalková 2017). For vehicles for up to eight persons, one only needs a driving licence. With no resting regulations imposed, the drivers often drive for thousands of kilometres without sufficient rest, which has led to serious car accidents involving deaths and casualties among care-workers.

The activity of recruiting agencies is the only area where states have directly intervened with regards to care mobility. In Romania, a recent legislation change no longer allows recruiting agencies to demand recruiting fees from care workers. According to Art. 8(5) of Law 232/2017 of 29 November 2017 (Parlamentul României 2017), intermediary agencies registered in Romania are no longer allowed to charge commissions to Romanian citizens when mediating employment contracts abroad. Some Romanian care workers we interviewed consider this change a major development intended to address reported exploitative situations in which care workers pay fees to both Romanian agencies and agencies in the country of employment. Although the amendments entered into force in March 2018, care workers continue to report cases in which agencies demand employment fees.

Another recent complaint of care workers refers to the recently-introduced indexation of child benefits in Austria. As of 2019, children who reside abroad and whose parents work in Austria – the case of most 24-hour care workers – will receive child benefits in line the purchasing power in the country where the children reside (Müller 04.01.2018). The main argument against the adjustment, which in effect leads to a reduction of child benefits for Romanian and Slovak care workers, is that it discriminates against them based on their specific situation,¹³ and it treats EU citizens in an unequal manner (Die Presse 17.04.2018). As child benefits in Austria remain an important incentive for migrant carers to work in

¹³ As 24h/7 care in private homes does not allow women, for practical and financial reasons, to take their underage children with them to Austria, the children continue to live in Romania and Slovakia respectively.



Austria, it is expected that the reduction in child benefits, to be implemented as of 2019, will lead to a decrease in the numbers of migrant care workers in Austria.

Slovakia is currently examining the practises of recruiting agencies, particularly with regard to contracts between agencies and caregivers, as well as transport regulation.¹⁴ The Ministry of Labour, Social Affairs and Family created a short information pack for persons who are interested in care work in Austria (MPSVR 2017),¹⁵ made it available on the Ministry's website, and distributed it to Local Offices of Labour across the country. In general, the area of job procurement was subject to high criticism from Slovak interview partners, and was reported an area with urgent need of intervention.

3 Methodology

As policymakers' perception plays a key role in the decision-making process and policy processes (Morrison *et al.* 2015: 7; Petticrew *et al.* 2004: 813), this paper looks at policymakers' perception of impacts of out-mobility for care work. This approach – to consider perceived effects of particular phenomena – originates in theories concerning ways in which human beings recognize problems and make choices, as well as on how they perceive reality and problems to be addressed (Parsons 1995: 337). For instance, research on the use of evidence in particular health policies in six EU countries found that, in addition to “cultural circumstances and traditions in appreciating evidence”, decision makers' personal beliefs and perceptions influence their interaction with researchers (Van de Goor *et al.* 2017: 279) which in turn influences how evidence is being considered in decision-making processes. Against this background, perception of impacts of care-work mobility on

¹⁴ In Slovakia, care work reached the public agenda in 2017 when care workers began to lobby for their rights. This was partly prompted in October 2017, when a mini-bus transporting seven care workers between Slovakia and Austria was involved in a fatal accident (Michalková 2017). All the passengers lost their lives – they had been constrained by their employment agencies to use that particular mode of transport. As the accident took place on Slovak territory, it triggered a national debate on the issue of mobility for care work and recruiting agencies (Vanoch 2017). Care-givers requested institutional reaction in the area of recruiting agencies (MPSVR, 2017a) and increase of social subsidies to informal carers to be similar to average income of caregiver in Austria (about 700€ per month)(TASR 2017). The latter was considered as unrealistic by the Ministry of Labour, Social Affairs and Family which is planning a continuous increase of financial contributions to a social care including the planned increase of social benefit for informal care.

¹⁵ See the online version of the material here: <https://www.employment.gov.sk/files/slovensky/uvod/informacie-media/informacie-opatrovatelky.pdf>.



health, education and long term care provisions offers a better understanding of policy responses to (perceived) impacts.

For the purpose of this study, “care-work mobility” refers to live-in care-givers as a specific sub-category of care-givers, most often without any professional education in this field,¹⁶ who are self-employed as carers in private households in Austria (described in the previous section). In terms of demographic profile, live-in care-givers have a higher average age compared to other care-givers and are often of pre-retirement age (Bauer and Österle 2016; Degiuli 2016; Winkelmann, Schmidt and Leichsenring 2015). For several reasons, the focus of the enquiry is narrowed further to live-in care-givers involved in elderly care in private households. The first reason is that the mobility of this category of care-givers is widespread (and constantly increasing) (A. Anderson 2012). Second, it involves various mobility patterns such as commuting and circular or short-term migration (Lutz 2011; Morokvasic 2013). Third, it often includes precarious labour conditions due to the specific organisation of care work in private homes (B. Anderson 2000; Winkelmann, Schmidt, and Leichsenring 2015). Care work for the elderly performed in private homes is organised as self-employment, with the care worker being an entrepreneur. Therefore, the relationship is not one of employment (with the private home being the employer and the care worker the employee) but is a business relationship where conditions of work are not regulated by labour law.

The research addressed the perceptions of key stakeholders in Romania and Slovakia with regard to two main questions:

1. To what extent has the mobility of care workers from Romania and Slovakia affected the provision of education, healthcare and long-term care in these two countries?
2. How are public institutions in the education, healthcare and long-term care sectors in Romania and Slovakia reacting to care-work mobility (particularly to care workers’ out-migration)?

¹⁶ Although the sector does not require professional training, nurses are represented in this group as well, due to the barriers to entering professional services abroad (addressed later in this paper).

As sub-topics, the research looked into the relevance of the mobility patterns of care workers for sending countries and the provision of informal care within families of mobile care workers.

In a first step, a comprehensive literature review was conducted by systematically looking into the relevant academic literature and policy documents in both EU and particular national contexts. In addition, previous relevant research was consulted and a limited data analysis of the available quantitative resources and statistics was conducted (Sekulová and Rogoz 2018).

In a second step, fieldwork at both national and local levels was planned in Romania and Slovakia. The fieldwork methodology, summarised below, was detailed in a manual which included ethical considerations for the research and which received the approval of the ethical commission of the Austrian Academy of Sciences.

Semi-structured interview guidelines were developed for two main categories of respondents (involving several other categories described below) – experts and care workers. The interviews followed a general script and covered a pre-defined list of topics (Bernard 2006). Like Gläser and Laudel (2009: 117), we conceptualised expert interviews as those individuals who have an expert role in the social setting under investigation. The main stakeholders covered in the research included representatives of the relevant institutions at the national, regional and local levels (see below for examples of the relevant local level institutions) and of public authorities (municipalities and local self-government). Also included were policymakers and administrative staff, the equality body,¹⁷ representatives of the relevant institutions at the local level (e.g. schools, local and regional labour and social-care offices), service providers (e.g. placing agencies, healthcare and social-service providers), civil society stakeholders, academics, mobile care-givers and adult members of their families.

¹⁷ Institution that monitors and reports situations of discrimination and promotes equality.

The sample for both the research on the care needs of families in relation to institutional services and that on the perceived impacts of care-related mobility and migration on education was further defined as described below. In order to gain a perspective on the needs of families in relation to institutional care services, the ideal scenario was to include four “cases of mobile families”, for every country under study (involving 8–10 respondents for the perspectives of mobile individuals/families).

For the thematic focus on the perceived impact of care mobility on the education system, our research included a “micro study of the school”. This data-collection technique consisted of mainly semi-structured interviews conducted in selected compulsory-education-level schools (in which children aged between 6 and 16 years are enrolled) with teachers, school directors, school psychologists and, where accessible, parents. The table below provides for an overview of the types of stakeholders interviewed, as well as the justification for doing so.

Categories of stakeholders interviewed	Reasoning/comments
Experts in the relevant areas	Academics and independent experts in relevant areas were interviewed in order to get a better general picture on care work mobility and its perceived impacts on countries of origin.
National level institutions	Ministries, NGOs and political organisations operating at national level, equality bodies, government agencies responsible for national level policies regarding labour mobility in general and health care, education and long-term care in particular provided for the national-level perspective on care work mobility.
Regional level institutions	County-level administration responsible for developing and implementing policies in the areas of health care, education and long-term-care provided

		for their perspective on care work mobility's impacts on the access to public services in these areas.
Local level		
	Public institutions	Municipalities and local-level government, service providers, civil society organisations active at the local-level etc. provided information with regard to impacts of care work mobility at the local level in relation to the access to health care, education and long-term care.
	Case study of schools (compulsory education level)	At the local level we interviewed teachers, directors, school psychologists and, where possible, parents/adults responsible for students in that respective primary school. This allowed for a better understanding of the perceived impact of care work mobility on education attainment.
	Cases of "mobile" families	A case consists of two respondents from one family – a mobile caregiver and another adult family member caring for a dependant in the country of origin and who is therefore able to speak about the care needs of families and access to services of health care, education and long-term care (e.g. partner/spouse or parents of mobile caregivers).
	Care workers	Care workers interviewed provided for their experience with regard to mobility for care work and the care needs of their families, as well as possible impacts of care work mobility on health care, education and long-term care services in their country of origin.



The fieldwork was conducted between October and December 2017, with several follow-up interviews taking place between January and March 2018. In total, in Slovakia, 32 persons were interviewed and four provided a response via email (17 responses at the national level, 16 collected from local-level institutions and four “mobile-family cases” – four care-givers and three family members). In Romania, 27 persons were interviewed and 2 provided a response via email (6 interviews at the national and 13 at the local level, 10 care workers and one family member – which included one “mobile-family case”). The respondents were offered anonymity and their contribution was considered only if they agreed to provide the researcher with their informed consent (either in writing or recorded). All interviews were recorded with the consent of the interviewees – if the person interviewed declined to be recorded, extensive notes were taken during the interview and completed after the interview was finalised.

The Slovak region for the local-level research was selected according to the following criteria: out-flow of migrants and commuters involved in care work, an above-average representation of mobile care-givers among the migrants, and access to the field. The selected region is in Eastern Slovakia, from which the majority of care workers (working in Austria) came. The county-level included a small rural district with an over-representation of care-givers among migrants. The Romanian research region was selected according to two main criteria: the accessibility of the field and various mobility patterns. Regional and local fieldwork was conducted in a county in Eastern Romania.

The fieldwork was influenced by the particular contexts in these two countries. Since early 2017, Romania has been facing mass protests against the changes in the justice system adopted by the government (Karasz 2017; REUTERS 2017) while, in the autumn of the same year, changes in the social security system (including the calculation of pensions) and new taxation led to other mass demonstrations across the country (Observator 2017). Challenging access to experts in Romanian institutions has been acknowledged in the literature on public administration (Andrei, Profiroiu and Oancea 2012) and existing research with public institution representatives (Van de Goor *et al.* 2017). In our experience, difficulty of access was determined by two main factors – the frequent changes of government (three governments between November 2016 and March 2018), and the



politicisation of public administration, particularly at the local level. Against this background, it is important to mention the relatively low response rate among relevant Romanian stakeholders and their refusal to give informed consent, particularly at local level. With few notable exceptions, local-level institutions consulted for this research do not seem to have procedures in place to communicate to the public their daily activities.

Access to public institutions was not an issue in Slovakia. Care work seems to have reached the public agenda, since care workers now lobby for their rights, supported by a Member of Parliament, especially since October 2017 when a mini-bus transporting care workers between Slovakia and Austria was involved in a deadly accident (for more details see Section 3) (Michalková 2017). This triggered a national debate on the issue of mobility for care work and recruiting agencies.

Between the time of the fieldwork – October to December 2017 – and writing up this paper several changes emerged, also as a result of lobbying done by the care workers themselves and several supporting organisations. This has been covered through continuous review of the relevant policy documents and public debates in the two sending countries in our study. Considering the complexity of the phenomenon studied, we cannot guarantee that all the relevant categories of respondent at the institutional level are represented in our samples. The number of interviews conducted in each country was limited and only one specific region was used in each. However, the diversity of the methods employed (combining qualitative research and secondary analysis of relevant publicly-available sources) allowed us to collect the relevant information on the perceived impact of care-work mobility and the institutional responses from the relevant actors – national and local institutions, and various experts.

In order to analyse the data we employed qualitative content analysis using NVivo10 and MAXQDA software. The coding process consisted of two main stages. First we coded the material on the basis of pre-set codes derived from the conceptual framework. This was followed, in a second stage, by another round of coding – themes and categories deriving directly from the collected data in relation to the researched dimensions.

4 The perceived impacts of care mobility from Romania and Slovakia and the sending countries' institutional responses

Through their institutions and policies, states shape the organisation of care. Institutional and policy frameworks, the effects of care migration on long-term care systems in receiving countries, and the role of welfare states in these processes, were the main focus of scientific examination (Anderson and Shutes 2014; Lutz 2011; Österle and Bauer 2012; van Hooren 2016). However, institutional and policy frameworks play a very important role in shaping the organisation of care and the actual effect of care mobility in the sending countries too, which was, as argued by Prescott and Nichter (2014), elaborated on much less in the care-migration literature. Earlier literature examining the role of sending states revealed a close interlinkage between migrant-sending and migrant-receiving countries, including the influence of the origin country and subnational authorities on the actual position and integration of migrants within the host society or their assimilation within the diaspora in receiving countries (Bilgili and Agimi 2015; Nebiler 2013).

Sending countries influence and stimulate care mobility at different levels. They set the general frame for living conditions through regulating the different aspects of workers' social reality, and thus contribute to the latter's willingness to emigrate or to return from abroad. Similarly, Prescott and Nichter (2014) conclude that the state both explicitly and subtly stimulates and manages women's labour migration. In addition, on the one hand, the state is benefitting financially from care mobility through remittances and thus is active in the production and support of care mobility (also via training). On the other hand, the state has a role in responding to the unintended consequences of care migration, such as the decline in care available within its own borders, as well as the new needs emerging that require psychosocial and legal support/intervention.

The institutional context and respective origin states' responses may have many layers and aspects; therefore the thematic focus of our analysis is narrowed down to three specific care-related sectors: healthcare, education and long-term care. All three are expected to be



strongly influenced by care mobility, mainly because of the outflow of care workers to other European countries.

In order to address the question of how countries of origin are influenced by and deal with care mobility through national public policies, we first analyse the perceived impacts of care mobility within the three care-related sectors, and then discuss the institutional responses in these areas.

4.1 Education – perceived impacts and institutional responses

The body of literature on the effect of parent out-migration on children who remain in the country of origin (while the parents work abroad) shows various and conflicting results (Botezat and Pfeiffer 2014; Brown and Connell 2015; Giannelli and Mangiavacchi 2010). For instance, Arguillas and Williams (2010) find that mothers' migration positively affects the number of years that children stay in school, while McKenzie and Rapoport (2011) find that living in a migrant household lowers the probability of children finishing high school.

However, educational attainment is only one dimension of the effect which the migration of parents has on children who remain in sending countries. A study by Gassmann and her colleagues – *The Impact of Migration on Children Left Behind in Moldova* – used a large household survey to empirically measure the well-being of children from migrant households (Gassmann *et al.* 2013: 23). Well-being was conceptualised through a series of dimensions, with each dimension quantified with the help of several indicators corresponding to the different age groups of the children. The dimensions used by the author are education and early childhood development,¹⁸ nutrition, material living standards, social protection, information and communication, and emotional well-being. With regard to education and early childhood development, the study finds that "there are no significant differences between children from migrant and non-migrant households but, within migrant households, who in the household has migrated does seem to matter"

¹⁸ For education and early childhood development, the authors use the following indicators: 0–4 years: care-giver plays with the child at least three times a week; 5–6 years: the child is attending pre-school; 7–17 years: the child is attending school at the appropriate age.



(Gassmann *et al.* 2013: 13). Children cared for by a grandparent while the mother is abroad have, in general, worse outcomes in the information and communication dimension, while those cared for by a grandparent while the father is abroad are worse off in terms of emotional well-being. The study also found that "the duration of the mother's migration is positively associated with education and negatively associated with health"; however, "if children are left in the care of someone other than the parent or grandparent [the study found] negative outcomes on education and nutrition" (Gassmann *et al.* 2013: 23).

However, a comparative study on the education of children in Mexico and Indonesia whose parents worked abroad and in other areas of these countries (internal migration) finds that "regardless of the migrant stream or setting, the overall relationship between migration and children's education is negative or neutral" (Lu 2014: 1096–97). In addition, the author concludes that the way in which the parents' migration affects their children's education should consider the context in which the migration takes place as well as the family situation (e.g. parents' education, the age of the children etc.), and should not be considered in isolation.

A study on the effects of Chinese rural–urban parental migration on children's health and education outcomes (children left in rural areas) finds that "both father and mother being away at some stage of children's life adversely affect children's school achievement measures by both Chinese and mathematics test scores" (Meng and Yamauchi 2015: 23). Meng and Yamauchi (2015) look at the share of the children's lifetime during which their parents were away in relation to the children's education and find, in addition, that children left in rural areas are more likely to go to boarding school, and therefore spend less time studying at home, after classes. Moreover, migrant household spending on private tutoring was found to be lower than in other households.

To sum up, the literature on the impacts of parents' migration on the education attainment of their children finds various results. While the overall negative effects require particular conditions (such as parents' level of education, and whether children live in rural or urban areas), some studies find no particular negative effects with regard to school achievements of children whose parents migrated abroad for work as compared with those whose parents



did not migrate (Gassmann et al. 2013). However, as we will show later on in this section, we found that parents' migration is perceived to have a negative effect on education attainment, particularly by the local level stakeholders. As we show in a review of the literature on care work and its impacts on countries of origin (Sekulová and Rogoz 2018), research has been focusing on the social impact of migration on migrants' families remaining in the country of origin, rather than on the impacts of migration on systems in sending countries.

4.1.1 General view of the current situation – compulsory education in Romania and Slovakia

The Romanian compulsory education system is centralised, with the Ministry of National Education having the main responsibility for “education strategy, policy and delivery” (Kitchen *et al.* 2017: 38). Current debates address the salaries of teachers, curricula and school books (European Commission (EC) and Directorate-General for Education and Culture 2017a), corruption in the system (Copăceanu 2017), and – to a more limited extent – underage students returning to Romania after living abroad (what has been called re-migration).

Romania has the lowest EU public expenditure on education – 3.1 per cent of GDP in 2015; the EU average was 4.9 per cent. This low public spending on education is reported to contribute to a higher burden on households' budgets for education (European Commission and Directorate-General for Education and Culture 2017a: 5). Compulsory education covers 11 years of schooling – from a preparatory grade (before the first year of school) to the 10th grade of upper-secondary education (Kitchen *et al.* 2017: 46), with students from six to 16 years old. Combined with high-stakes examinations, particularly in secondary education (e.g. high-school entrance examinations, baccalaureate), a system of private tutoring is in place at all school levels. Save the Children organisation reports that families can pay up to €1,250 annually for tutoring (Kitchen *et al.* 2017: 93).

Like Romania, compulsory education in Slovakia covers 10 years of schooling for students between six and 16 years old. Most students are enrolled in public schools, but there are also church and private schools available. All schools receive some public funding, with



private schools receiving more than 50 per cent funding from public sources (Shewbridge *et al.* 2014: 16). In 2015 Slovakia's public expenditure on education was 4.2 per cent of GDP. Education represented 9.3 per cent of total government expenditure, while it was 10.3 per cent for the EU (European Commission and Directorate-General for Education and Culture 2017b: 7).

According to the 2016 Slovak care workers survey, 15 per cent of care-givers in Austria have children under 15 years old, with 2.1 per cent younger than six (Bahna 2016). To illustrate the figure of children living in Slovakia while their mothers work abroad, it is worth mentioning that there are about 30,000 children in Slovakia who receive child benefits from Austria (Der Standard 2018).¹⁹ There is no similar data for Romanian care workers abroad.²⁰ Data from the Romanian National Authority for Child Rights, Protection and Adoption (henceforth referred to as "ANPDCA") shows that, by the end of June 2017, there were 74,405 families working abroad whose children live in Romania and were registered with the local authorities²¹. By the end of June 2017, 96,723 children were registered who had at least one parent working abroad, out of whom 18,403 had both parents living abroad. According to ANPDCA, the numbers are, in fact, higher, the data only representing registered cases.²²

4.1.2 The impact of mobility on education – stakeholders' perspective

Our research conducted in Romania and Slovakia shows that there is little recognition, at the level of national institutions, of any impact of care-work mobility on the education systems in these countries. However, the perceived impact of care-work mobility on compulsory education in each country varies. At the local level, stakeholders underline the various effects which the mobility of care workers has on families in general and on children

¹⁹ Family benefits from Austria are an important motivational factor for Slovaks undertaking care work in Austria (Bahna and Sekulová 2018)

²⁰ An OÖN article from 4 May 2018 reports 15,500 children of Romanian parents receiving benefits. These benefits are not limited to the children of care workers. The article mentions 30,600 for Slovakia. For more information visit: <http://www.nachrichten.at/nachrichten/politik/innenpolitik/Familienbeihilfe-Regierung-setzt-bei-Kindern-im-Ausland-den-Sparstift-an;art385,2886190>.

²¹ Data is collected by local authorities (social service departments) and shared with the county authorities, who then share it with ANPDCA.

²² ANPDCA does not collect information on the type of work in which these parents engage abroad.



remaining in the countries of origin, in particular in Romania. Although the relevance of care-work mobility is not recognised as such (in relation to the compulsory education system in the country), it is acknowledged that it is mostly the engagement of women in care work abroad which has negative effects on children remaining in the country. In Slovakia, the different mobility patterns of care workers seem to influence the perceived impact of care-work mobility on education. Although care work is acknowledged by national-level institutions as relevant for Slovak women and linked with intra-EU mobility, it is not regarded as negatively impacting the well-being of children for two main reasons. First, Slovak women working in care abroad are in the middle or later stages of their lives, and their children are therefore older.²³ Second, mobility patterns between Slovakia and Austria, for instance, allow these women to reconcile working abroad with their families' lives.²⁴

Both ANPDCA and local-level stakeholders, including school representatives, reported that parents who leave the country to work abroad and whose children continue to live in Romania do not report this to the local authorities. Children with parents abroad and with no registered legal guardian (those living with members of the extended family, for instance) pose an administrative challenge when it comes to accessing education and health-care provisions. According to Law 272/2004, parents with underage children in their direct care who wish to work abroad are required to declare their intention to leave the country (and leave their children in someone else's care) to the Social Services (*Serviciul Public de Asistență Socială* – SPAS).²⁵ Based on this formal communication with SPAS, Social Services will visit the home of the person with whom the child will live (while the parent is abroad). The request to leave the child with another person (other than a parent) then goes to the local courts. Based on the SPAS recommendation, the court decides whether the person can or cannot take care of the child. If the response is positive, the court informs the person of their rights and responsibilities. The maximum period for which the court can

²³ Data from Caritas Austria obtained through direct consultation shows that the average age of Slovak care workers in Austria is 52 while that of Romanian care workers is 49 years old.

²⁴ Most Slovak women working in care in Austria commute between their homes and their place of work every 14 days while most Romanian women commute every 21 or 28 days.

²⁵ Law 272/2004 on child protection and the promotion of the rights of the child, republished in 2014, includes Section 4, 'Protection of the child whose parents went abroad for work'. This section (which includes Articles 104–108) describes also the obligations of single parents to inform the local Social Services if they plan to leave the country.



entrust child-raising and supervision to another person is one year. Mobile care-givers involved in this research reported that they do not declare the fact that they leave the country because they do not want Social Services to visit the family (in case the child is left with members of the extended family).

Schools face particular challenges when children are not officially registered as living with someone other than their parents, as they cannot approve transfers nor register the children for extracurricular activities. For day-to-day activities, teachers communicate with the person in *de facto* charge of caring for the child but need the legal representative's signature for official documents.

The literature on the impact of parental migration on the education of children who remain in the country of origin shows different effects, depending, among other factors, on the family dynamics and on whether it is the mother or the father who goes abroad for work (if this is the case). Interviewed local-level stakeholders in both countries regard the issue of migration in general (and intra-EU mobility in particular) as extremely relevant for the well-being of children, education being a crucial aspect of children's lives. Interviews with teachers in Romania revealed the perceived negative impact of parents' migration on their children's performance in school – almost all interviewees describe the situation of these children as devastating, particularly since most of them are not performing well in school (e.g. are at risk of having to repeat the academic year). Interviewees also reported extreme cases of this negative impact, citing examples in which a child with parents abroad was in a deprived situation, either having to take care of him- or herself or being abused by the person nominally charged with the child's care.

Psychologists working with schools and consulted for this research in Slovakia regard migration as a very serious issue which is being overlooked in the country, particularly in relation to education. According to one psychologist, family cases are highly individual and the impact depends upon how each family mobilises its resources. Teachers interviewed in Romania associate poor performance in school with parental migration, although it is acknowledged that the main cause is not migration as such but the absence of guidance in children's lives. Romanian teachers consider that parents' absence from home, even for



quite short periods of time (months rather than years) has a negative impact on the children's well-being – for example, these children are often unhappy and have to grow up faster than the others – and on their overall school performance. Similarly, the Slovak psychologists interviewed for this study, while perceiving migration to have an overall negative impact on the well-being of children, provide particular examples of families in which the parents do not get on or have social problems. One psychologist reports that most of the children who attend the psychological centre have at least one parent abroad. Schools in Eastern Slovakia included in this research report that the most common pattern for second-grade children experiencing behavioural issues is to have fathers working abroad.

To sum up, local-level stakeholders in both countries reveal an ambivalence in narratives on the impacts of migration/mobility on the educational attainment of children with parent(s) working abroad. The general perceived impact is a negative one, but it is acknowledged, through particular examples, that impact is contextual – the overall impact of parental migration on children's educational achievements also depends on the individual migration process as well as on the structure of the family, including the age of the child.

4.1.3 Institutional responses

The impact of care-work mobility on the education of children whose parents are working in care abroad is perceived in different ways in the two countries. In Romania, national-level institutions acknowledge that it is mostly women who engage in care work abroad, thus their absence from home has negative consequences for the general well-being of their children (Irimescu and Lupu 2006). In Slovakia, national-level institutions see no such negative impact on school achievement, as most mobile care workers from Slovakia are women in their mid- and later life stages who do not have young children who could have potentially been affected by the absence of their mothers. For this reason, the experts interviewed for this study reported a low-level institutional response.



In Romania, the institutional infrastructure responsible for reacting to the perceived negative impact of parental migration abroad on children remaining in the country is similar to the one put in place for children in compulsory education. In 2005, the Romanian Ministry of Education approved the organisation and functioning of centres for educational resources and assistance at the level of each county.²⁶ These centres (*Centrul Judeţean de Resurse şi Asistenţă Educaţională* – CJRAE) are affiliated with the Ministry of Education, coordinated by county-level school inspectorates (*Inspectoratele Şcolare Judeţene* – ISJ) and funded by directly elected county councils (McKenzie and Rapoport 2011b) (MECTS 2011).²⁷ These centres coordinate, monitor and evaluate the education services in the counties and offer a variety of other services: psycho-pedagogical assistance, speech therapy, orientation services from special schools to mass schools and vice versa, information and counselling services for teachers, children and parents, counselling and prevention services for juvenile delinquency, etc. School psychologists are employed by these centres. Similar centres exist in Slovakia, where pedagogic and psychological counselling and prevention centres²⁸ have regional competences. Their main mandate is to provide complex services in the areas of psychological support, pedagogy, diagnostics and prevention of, for instance, school dropout for children and youth. The centres are affiliated with the Ministry of Education.

At the local level, according to current legislation, the Public Services for Social Assistance (*Serviciile Publice de Asistenţă Socială* – SPAS) from each Romanian territorial administration are required to facilitate and maintain ongoing contact between the legal representative of a child whose parents are abroad and school representatives, as well as to organise quarterly meetings with those *de facto* charged with the care of the child in order to make sure that children affected by migration are being treated correctly and fully enjoy their rights. In general, field work in Romania revealed a lack of cooperation between institutions at both national and local levels. Cooperation exists at the level of strategies and national plans; though, in practice, this is based on personal rather than institutional contacts. This might be caused by the politicisation of public administrations (Andrei *et al.* 2012), a finding

²⁶ The Romanian Ministry of Education issued Order 5418/ of 8 November, based on the Government Decision (H.G.) 1251/13 October 2005 on measures to improve the learning, training, compensation, recovery and special protection of children and youth.

²⁷ They function today according to Order 5555/7 October 2011.

²⁸ Established based on the Act on Education 245/2008 Coll (Ministry of Education 2012) by the county administration.



confirmed by the Institutional Strategic Plan of the Ministry of Labour and Social Justice. In addition to increases in staff, the Plan mentions several times the need for a “better collaboration between sectors or authorities for the implementation of the current legal framework” (MMJS 2017: 51).

In practice, support for children “left behind” is offered by institutions in collaboration with NGOs – the Ministry of Education, for example, works with Save the Children to offer support to children with parents working abroad. In addition, support is offered to children and their adult care-givers (other than their parents) in 16 local centres across the country.

According to a local-level stakeholder, the Romanian education system, in its current form (based on the actions of three actors: the child, the school and the child’s family), does not allow for more intervention by the school; differential treatment applied for children with parents abroad is regarded as discriminatory, as it can put more pressure on a child who already has to deal with a very difficult situation. Schools keep a record of those children with at least one parent abroad; this is communicated to the County Education Inspectorate (*Inspectoratul Școlar Județean* - ISJ). ISJ collects this data, but does not share it with the Ministry of Education unless specifically asked to do so. Research in a county in Eastern Romania showed that support offered to children with parents abroad is *de facto* coordinated by teachers who are aware of the family situation and are in contact with the person in charge of the child’s care.

4.1.4 *The reintegration of children returning from migration abroad*

Although not a direct response to parents’ mobility for care work, the return migration and reintegration of children into the public education system of their country of origin is identified by national stakeholders in both countries as a significant aspect of education in relation to migration/intra-EU mobility. In Romania, specific pilot projects were put in place to support children who returned to Romania after being enrolled in school abroad (*remigrați*) (Brebuleț 2018). Once their parents decide to move back to Romania, these children enjoy the right to education, as school is free and mandatory up to the 10th grade. However, our interviews with local stakeholders revealed an unclear methodology for



enrolling children in school following a period of schooling abroad. In addition, the process of reintegration into the school system depends both on whether a child is enrolled in school during the academic year or between years, on the country where s/he lived before (mainly from Italy, Spain or the UK), and on whether the child went to kindergarten in Romania before enrolling in school abroad. In the spring of 2018, the Ministry of National Education modified the means of recognition of years of education abroad in order to ease children's enrolment into the compulsory and upper-secondary school system. The Ministry (at that time the Ministry of Education, Research, Youth and Sports) reports that, between January 2008 and May 2012, 21,325 children returned to Romania from Italy and Spain and applied for recognition of their studies abroad (Luca *et al.* 2013: 13). According to the estimates of these authors, this number represents two-thirds of the total number of children who returned to Romania in that time period. Between July and October 2013, the Romanian Ministry of Education registered 4,874 requests for school enrolment (Ministerul Educatiei Nationale 2013). Other figures show that, in 2014, approximately 9,500 children returned to Romania and asked for recognition of their school years abroad in order to enrol in the Romanian public school system.

The Slovak Ministry of Education (and school representatives alike) acknowledges the importance of properly reintegrating pupils in the Slovak school system after a period of time spent in a school system abroad. However, the total number of return-migrant children to Slovakia is not available. In the academic year 2016/2017, about 2.7 per cent of students of compulsory-education age (16 or younger) were studying abroad (SCSTI 2018). As in Romania, reintegration into the Slovak education system takes place through procedures stipulated by law and internal directives (e.g. Act on Education 245/2008 Coll). In practice, such children have one year to (re-)adjust to the Slovak school system.

4.2 Healthcare – perceived impacts and institutional responses

Healthcare systems and care provision in sending countries are increasingly challenged by the ever-growing international outmigration (OECD 2015b), especially that of health personnel, which affects the structural aspects of healthcare provision. At the same time



international migration poses very specific health-related demands on healthcare provision to migrating/mobile persons.

Both countries in our research – Romania and Slovakia – are currently facing such challenges. The relevant literature highlights existing problems within the systems, such as the lack of regulation or territorial inequalities in Romania (Vladescu and Olsavsky 2009) and the lack of finances, quality, and delivery of services in Slovakia (Kapalla, Kapallová and Turecký 2010). The labour force shortages on the different levels of the health care system are one of the central areas of concern for health authorities in many countries, including Romania and Slovakia. These shortages result from unfavourable demographic structures, low numbers of educated professionals and, increasingly, from the emigration of professionals (Gurková et al. 2013; Stachová 2008; Vladescu and Olsavsky 2009). According to a recent European report on intra-EU labour mobility, in 2016 there were about 184,000 health professionals and 168,000 health associate professionals²⁹ (aged between 20 and 64) living in another EU country than the country of their citizenship (Fries-Tersch *et al.* 2018: 16). “In addition, there were 256,858 mobile personal care workers living in another EU Member State, almost as many as all other health professionals and health associate professionals combined” (*Ibid.*: 114).

4.2.1 *The perceived impacts of care mobility on healthcare*

Our national-level research participants – academic experts and government representatives – together with local-level respondents such as health professionals, practitioners and service providers in both countries, described the national healthcare systems as significantly lacking a sufficient qualified labour force, to which mobile care workers contribute. Both representatives from national institutions and academic experts from Slovakia highlighted the impact of this mobility on healthcare in hospitals and other professions in health and social care facilities, including long-term care (this sector is analysed separately later).

²⁹ This refers to the following categories: “medical and pharmaceutical technicians, nursing and midwifery associate professionals, traditional and complementary medicine associate professionals, veterinary technicians and assistants, other health associate professionals” (Fries-Tersch *et al.* 2018: 111).



In Romania, migration is regarded as having a negative effect on the healthcare system, though care workers' mobility in particular is not perceived as having a negative effect beyond the general perception of the effects of out-migration. The perceived negative impact in Romania referred mainly to the mobility (out-migration) of medical doctors and trained nurses. Most 24-hour care workers do not have nursing training; therefore their out-migration is not seen as problematic.

Although care mobility contributes to the existing deficiencies in Slovakia, according to our academic respondents, even the return of nurses working abroad would not solve the problem. The Slovak education system does not train a sufficient number of qualified workers to meet current demands within the healthcare system (Radvanský and Lichner 2013). Nevertheless, labour force shortages in healthcare do not necessarily suggest a lack of health workers with the required qualifications and skills, but rather that these people may be reluctant to work under existing conditions (OECD 2015b). Although the wage differences between Central and Eastern European countries and other (Western) European countries are quite significant and can act as a motivational factor for the out-migration of nurses, other factors are also relevant. For instance, in Slovakia, experts in the field of healthcare emphasised, as did other research on the motivation of nurses to migrate to Austria (Österle and Lenhart 2009), the strong dissatisfaction of nurses with the country's existing healthcare system. Nurses' low social status in society, lack of recognition, limited career opportunities and low position in the healthcare hierarchy, together with the domination of the authoritative knowledge of the doctors, all contribute to their overall demotivation, and consequently act as triggers for emigration. Furthermore, in both countries studied, administration in the healthcare sector is highly politicised. Consequently, the complex political-economic, historical and cultural factors which influence the migration of nurses (Prescott and Nichter 2014) must be taken into account in order to understand the specific national context of care mobility and migration.

The extent to which care mobility contributes to existing labour shortages was considered as marginal by respondents in both countries. In general, none were aware of the considerable percentage of nurses and healthcare assistants among care-givers in Austria,



for instance. Taking into account the extensive total numbers of care-givers from both countries, the share of nurses and healthcare assistants still seems to be reasonable.³⁰ However, this share has been continuously decreasing, due firstly to healthcare professionals' open access to formalised services,³¹ and also to nurses working in personal care in Austria, who occasionally move up into qualified employment opportunities in the standard healthcare or social services sector in that country (Bahna and Sekulová 2018; Bauer and Österle 2016).

The influence of care mobility on the quality of service provision in the origin countries was another factor mentioned by the experts. In Romania, the lack of trained nurses leads to positions in local hospitals being filled by less-trained personnel, thus causing a reduction in the quality of the service. However, according to the literature, return care mobility might equally have a positive effect (Dwyer 2007; Hongyan, Wenbo and Junxin 2014), perspective confirmed by our own research. Two experts in Slovakia – a representative of a public institution and an independent expert in the area of long-term care – emphasised that, in cases where care-givers return to Slovakia and to employment in the health or social care sectors, the experiences they have gained abroad may positively contribute to an improvement in the quality of delivered services. Thus, mobile care-givers, after years of practice abroad, are considered to bring enhanced skills, ideas and knowledge from which the country of origin may benefit (Dwyer 2007; Hongyan, Wenbo, and Junxin 2014).

More positive impacts were perceived by several other respondents. According to service providers in Slovakia, care work abroad steers additional financial resources into the Slovak healthcare system as, while care-givers pay their health insurance in Austria, they utilise healthcare services in the home country which, according to European legislation (EC 2009) is compensated for by Austrian social insurance institutions.

³⁰ Statistics are not available; however, if taking into account active trade licences and the estimated share of 20 per cent for 2016, we can expect about 4,400 nurses and healthcare assistants to be among Romanian care-givers and about 6,000 among Slovak care-givers.

³¹ Personal home care in Austria was an option before legal opportunities for nurses in European countries existed (Bahna 2014). The increased migration of nurses emerged, in particular, after EU accession and the harmonisation of EU directives with national education systems. Qualified legal employment in health and social-care institutions in EU countries is accessible for healthcare professionals, therefore nurses and care assistants choose employment in formalised sectors rather than in personal home care in Austria.



Last but not least, migration poses very specific health-related demands on healthcare provision to care workers or migrants themselves. Relevant literature emphasises the negative health effects of care mobility. In Slovakia, according to (Bahna and Sekulová 2018), the weakening of care-workers' health due to the demanding nature of their work abroad, to their long-term circular migration or travel between the two countries, or to psychological problems associated with their precarious work conditions, all featured in the life-stories of care-givers working in Austria. In the Romanian context, what was called "the Italian syndrome" affecting care-givers who provide live-in care to the elderly abroad is currently often referred to in the media. The syndrome, affecting women who migrated from Eastern Europe, involves physical symptoms such as pain and extreme fatigue, and develops into long-term depression and episodes of paranoia (Ciuhu 2018). The need for free psychological support for care-givers was repeatedly mentioned in the research narratives, as respondents in both countries underlined the negative effects of care work mobility on the health of care-givers, which consequently challenges national healthcare systems. Respondents in Slovakia (service providers, care-givers and organisations defending care-givers' rights) requested the incorporation of care mobility into the agenda of national healthcare institutions.

4.2.2 Institutional acknowledgement and response

National institutions in both sending countries under study were aware of care workers' mobility from their countries to other EU member-states. However, national policies do not reflect the specificities and particular effects of care mobility on the healthcare systems in these countries. The Slovak Ministry of Health acknowledges migration as an important factor influencing the current situation in the health-care system (particularly with regard to out-migration of doctors and nurses). For instance, a report on the current state of healthcare in Slovakia (Hlavatý and Liptáková 2011), published by the Ministry of Health, identifies migration as a significant contributor to the worsened access to healthcare in certain regions due to the high out-migration of younger doctors and nurses. In May 2018, the Ministry of Health announced new priority actions, among which an easier access for nurses from abroad (Hungary, Poland, Romania, Serbia or Ukraine) was identified as a potential solution for existing labour force shortages (Beňová 2018). According to the



Ministry's proposal, the legal access for professional nurses with appropriate qualifications might be subject to exceptions from rather strict conditions for accessing the Slovak labour market for third-country nationals. At the same time, the potential of caregivers and nurses returning from abroad, for instance those working in 24-hour personal care in Austria, was not addressed.

In Romania, the out-migration of medical doctors is considered to be one of the main negative aspects of mobility, as many Romanian doctors are now working in other European countries, but migration for 24-hour care is not regarded as a main issue. The increase of salary levels for medical personnel introduced in 2018 is hoped to encourage potential emigrants to stay in the country.

Public health institutions' responsibility to address the health-specific issues of care-givers was not reflected in either country. In Slovakia, for instance, institutions (including academia) in healthcare-related areas had not applied a cross-cutting focus on migration as an important factor contributing to health and social-care provision, as a result of which there is little data collection and analysis.

4.3 *Long-term care systems – perceived impacts and institutional responses*

Long-term care is most commonly understood as a range of health and social services for those – most usually elderly and/or disabled persons – who are dependent on help with their daily activities over an extended period of time (Cangiano 2014; Hirose and Czepulis-Rutkowska 2016; OECD 2015). Previous research has shown a huge increase in long-term care needs across Europe. According to projections (Bettio and Verashchagina 2012; Council of the European Union 2014), this trend is set to continue. Existing care systems are challenged by population ageing and an increasing share of frail elderly people in need of long-term care on the one hand, and by social factors related to changes in family structures on the other. The decline of intergenerational cohabitation, more single-person elderly households, the increased participation of women in the labour market and the decreasing ability of families to provide informal care, together lead to a growing demand for care provided from outside the family, a demand often met by migrant care workers.



Migration is one of the factors closely interconnected with long-term care. The issue has been studied mainly in the context of long-term systems in receiving countries and the role which migrant or foreign-born care-givers play in them (Lamura *et al.* 2010; Spencer *et al.* 2010). Meantime, the effects of care-workers' migration on the long-term care systems in their countries of origin have been neglected.

Long-term care and the public provision of social and health services are regulated differently throughout Europe. By way of comparison, Western European countries recognised new categories of “economic and social risk” (Council of the European Union 2014) earlier than did Central and Eastern European (CEE) countries, which include Romania and Slovakia (although, even in Western European countries, welfare states have been relatively late in addressing the issue). In CEE countries, public funding for long-term care remains long overdue, limited and characterised by fragmentation and an orientation towards providing social assistance (Österle 2010).

Like other Europeans, the Romanian and Slovak populations are ageing. According to Eurostat, in Romania the share of persons aged 65 and over grew from 14.7 per cent in 2006 to 17.4 per cent in 2016; in Slovakia it grew from 11.8 per cent in 2006 to 14.4 per cent in 2016. Projections estimate that those over 65 will make up 20.8 per cent in Romania in 2030 and 28.9 per cent in 2060; for Slovakia, 21.4 per cent is projected for 2030 and 35.1 per cent in 2060. Healthy life expectancy is 64 years for males and 59 for females in Romania while in Slovakia this is 62 and 60 years respectively (Council of the European Union 2014).

Ageing is expected to have a massive impact on Romania and Slovakia in the future, affecting significantly the fiscal aspect of long-term care and society. Healthy life expectancy – an indicator of years of life spent in good health, free of illness or disability – basically equals the retirement age in both countries. Persons over this age are extremely dependant on external care. Whether or not these older people are in good health during their longer lives is a crucial consideration for national policy developments (Council of the European Union 2014).



Currently, total public expenditure on long-term care as a percentage of GDP is low. In 2010 public expenditure on long-term care as a proportion of GDP was 0.63 per cent in Romania and 0.3 per cent in Slovakia, compared to the EU27 average of 1.8 per cent (Council of the European Union 2014). Projections of public expenditure on long-term care as a proportion of GDP indicate a 129 per cent increase in the EU15 as an average for the 2007–2060 period, whereas the projected increase will be 203 per cent in Slovakia and 349 per cent in Romania (Österle 2010), due to the rapid increase in the elderly population in both countries.

Previous research has identified migration and mobility as factors contributing to pressures on long-term care systems in sending countries (Council of the European Union 2014; Hirose and Czepulis-Rutkowska 2016; Österle 2010). The free movement of labour within the EU, together with an increasing demand for migrant labour in wealthier Western European economies, contributes to challenges for the long-term care systems of the CEE region, which is based on family-oriented care arrangements. As a certain proportion of those migrants go abroad in order to provide paid care labour – they leave their own family dependants in need of care in the country of origin – the family-based structure of long-term care in CEE is challenged. While richer Western European countries reacted to demographic transition through the development of long-term public policies, in poorer countries the consequences of migration on elderly and long-term care are severe because insufficient social-security systems leave families as the main providers of support without any external assistance (Stoehr 2013).

4.3.1 Long-term care systems in Romania and Slovakia

From an analytical perspective, focusing on the degree of formalisation and regulation of long-term care, both Slovakia and Romania subscribe to the “familist”/individualist model or “family care model” (Österle 2010). In this model, families and individuals hold the main responsibility for social care, while the state (through county-level administration and municipalities) provides basic care services and/or means-tested cash contributions. In both Slovakia and Romania the responsibility for care lies largely with families.

In Romania, the long-term care system is aimed at old and disabled persons and therefore most of those in need of medical care are included in the formal system (Council of the



European Union 2014). The National Health Insurance Fund and the state budget share financing at the central level, where the latter covers medical services. The National Council of Aged Persons coordinates long-term care.

Social care for the elderly is regulated by Law 17/2000³² according to which social-care community services consist of residential- and home-based services (both permanent and temporary), such as day centres (Council of the European Union 2014; Popa 2010). Social services provision falls under the local authorities; the financing mechanism combines central and local resources, with NGOs playing an important role in the delivery of services. While cash benefits and in-kind social and medicinal services are available to disabled persons, a supplementary allowance for a family member caring for a disabled person is also available (Council of the European Union 2014). In spite of the continuous development of long-term care services and the increasing diversity of provision, services do not meet the actual needs and demands of an ageing population (Popa 2010). Private facilities have increased in recent years in response to a rising demand for long-term care; however high fees makes such services affordable only for those better situated economically (Council of the European Union 2014; Popa 2010). According to data from the Ministry of Labour and Social Justice, by mid-June 2018, 210 home-care services were licensed to provide care services, of which 41 were public (MMJS 2018a). Thus long-term care is provided in Romania mainly on an informal basis.

In Slovakia, the long-term care system consists of formal care services provided either in residential institutions (nursing homes, hospitals, etc.) or at home by professional carers (Council of the European Union 2014; Repková 2011; Radvanský and Lichner 2013). The long-term care sector is coordinated by both the Ministry of Health – with regard to health provision – and by the Ministry of Labour Social Affairs and Family, although responsibility for social-services provision was delegated by decentralisation from national to local and county government (Act No. 448/2008 on social services). Municipalities are in charge of social services in Slovakia, and have the main responsibility for community social-care

³² For the consolidated version, republished in the Official Journal (*Monitorul Oficial*) to include several subsequent changes, see: http://www.mmuncii.ro/j33/images/Documente/Legislatie/Asistentia-sociala-2018/Legea_17_2000_la_18-01-2018.pdf.



provision to the elderly while regional-/county-level administration is responsible for residential services for the elderly, disabled and chronically ill. The financing scheme consists of health insurance and social welfare payments, other costs being covered by lower-level administrations (municipalities and regions) through taxes and co-financing by care recipients (Radvanský and Lichner 2013). Private services are somewhat rare due to the low purchasing power of the social and health services' clientele (Repková 2012; 2011). Formal care provision both in institutional and in home settings only covers around 14 per cent of those who need care in Slovakia (Radvanský and Lichner 2013). Family care arrangements play the main substantial role in long-term care provision. The long waiting lists for residential care is another component of the long-term care systems in Romania and Slovakia (Council of the European Union 2014), highlighting the strain this puts on family-based care arrangements.

4.3.2 The importance of informal care

Informal care³³ in home settings is the preferred and main form of care provision in both the origin countries in our study. Informal care relies heavily on unpaid female carers. Both countries offer services and/or cash contributions to a person in need of care and a wage-loss compensation for the carer. In Romania, informal home care can be provided by the partner or relatives of the dependent elderly. The carer can apply to work part-time only and for financial compensation from the local budget. However, there are no cash benefits in Romania for those caring for the elderly. Legalised cash and in-kind benefits are available for those who are officially recognised as having a disability (Popa 2010). In Slovakia the system of means-tested cash contributions is available to informal carers, tailored to those on a low income. As our research indicates, cash contributions do not sufficiently compensate the care-giver for loss of income, and this may therefore motivate them to search for care work abroad. In Slovakia, 82 per cent of long-term care workers are providing care informally (Radvanský and Lichner 2013, 2); of these, only a third are receiving any financial compensation for the care provided (2013, 3). No statistical data on

³³ The concept of informal care has diverse interpretations. In the Slovak legislation, for instance, an explicit definition does not exist, but it is most commonly understood as the long-term care provision in the home setting by a caregiver with no professional training in the field and who shares the household with the person being cared for (Repková 2012).



informal care in Romania is available, even though it dominates long-term care for the elderly (Council of the European Union 2014; Popa 2010). In both countries, cultural attitudes towards using residential services limit their use as the family is considered responsible for the care of other family members.

4.3.3 Perceived impacts in the context of long-term care

National level stakeholders involved in this research acknowledged the effects of care-work mobility in relation to labour-force shortages, including inter-related aspects such as the lack of funds, limited availability or access to long-term care services. Romanian institutions mainly mentioned the out-migration of personnel within care-related sectors. Structural shortages in the labour force, the limited availability of social services, and scarce financing across the long-term care system in Slovakia were identified by experts as main problems to which care mobility contributes. National public institution representatives in Slovakia acknowledged care mobility and its effects as a factor impacting more significantly on individual families rather than on the different forms of formalised care services. However, the relevant literature (Radvanský and Lichner 2013) reports a massive demand for care-givers in the formal care sector.

County-administration representatives and local social-service providers in Slovakia perceived out-migration, though not necessarily towards care sectors abroad, as contributing to the current regional rise in single-person elderly households. Many elderly people are thus left in an extremely problematic situation as, in rural areas, community services may well be under-developed or unavailable. Not-for-profit organisations in Slovakia reported that they provide formal care services to those elderly people whose main care-givers have left to do the same work but in Austria – which is common, although the quantification of these cases was not possible, as local NGOs do not collect such statistics. Similar developments have been identified in the literature for Romania, where out-migration results in an increase in the number of elderly people living alone and who are in need of home or residential care. As for Romanians living in rural areas, formal care provisions are limited and services are insufficient, with the situation leading to a long waiting lists for beds or places in specialised institutions (Council of the European Union



2014). According to Eurostat, in 2015 35.5 per cent of the population aged 65 and above were living alone in Romania, and 30.4 per cent in Slovakia (EUROSTAT 2015). Compared with their European counterparts, the elderly in Eastern Europe face serious levels of loneliness due to their lower socio-economic status, poor health, and limited opportunities for social participation and for experiencing rewarding social relationships (Hansen and Slagsvold 2015).

In both countries, local-level stakeholders, including municipalities, were more aware of the effects of care mobility on the individual family, the local community, and the institutions than were national stakeholders. The perceived impact on the sending region was quite positive, care-work mobility being regarded as a coping strategy for many households in economically deprived regions. According to our interviewees, the temporality of the stays abroad and the commuting patterns usually enabled care-givers to reconcile work and family life; thus women would often remain involved in certain informal long-term family care obligations (see also Bahna and Sekulová 2018; Bauer and Österle 2016).

With regard to long-term care, local stakeholders declared a huge increase in demand for formal institutional services over the last few years. In Slovakia, the county representative in charge of formal social-care services declared an increased demand for daily residential care and services due to the ageing of the population in, and out-migration from, rural areas. In line with weakening family caring capacity, experts on the local level gave particular emphasis to the under-development of formal community services, which are increasingly in demand by the elderly, for whom the municipalities are responsible in Slovakia. In line with our findings, a SWOT analysis of national priorities for the development of social services for 2015–2020, published by the Ministry of Labour, Social Affairs and Family (MPSVR 2014), identifies as the main weaknesses of the existing system a huge increase in demand for social services for the elderly, an over-representation of residential over mobile services, and the absence of the concept of long-term care in the legislation.

Care mobility was perceived as having only made a minor contribution to structural system deficits. According to service providers and non-governmental organisations, fluctuations towards other non-care-related work sectors either in Slovakia or abroad are more



important. Positions within the gender-segregated long-term care sector are poorly paid, feminised, physically and psychologically demanding, and have a low social status in society (Bettio and Verashchagina 2012). In Slovakia, filling care-giver positions is currently extremely difficult in the economically well-developed Western parts of the country whereas, in the economically less-developed Eastern and Southern parts, the occupation of care-giver and jobs in the social-care sector remain attractive (although the hiring process lasts longer and applicants' qualifications are rather low).

Rather than contributing to system shortages, care mobility was perceived as having an effect on the quality of service provision in sending countries. Here, contradictory effects were mentioned by different actors. While, for some, those working in care mobility abroad have the potential to bring new skills, knowledge and experiences back to Slovakia, others perceived the effect of care mobility on the quality of service provision in the home country in rather negative terms, not believing that returning care workers would necessarily bring added value to their work after leaving their job in Austria. In Slovakia, practice in 24-hour personal home care in Austria was not considered as an advantage or providing added value, according to service providers on the local level; these doubts are based on the latter's experience of employing ex-care-givers within formal institutional care in Slovakia. The skills would not be applicable, the carers would not be sufficiently prepared for work in a formal setting and would need more practice (this is not applicable to those who had worked in formal settings in health and social care in Austria). In Romania, care work was seen as directly contributing to a decreasing quality in formal long-term care, where the quality of service provision decreases because trained care personnel are leaving to work abroad and are being replaced by insufficiently trained employees.

4.3.4 Informal care through the lens of care mobility

According to our research, care work mobility to Austria and the absence of care-givers in the countries of origin has greater relevance for informal care at the level of the family than for institutionalised formal care structures in both countries. The majority of mobile care-givers have informal family care obligations at home – for their own parents, children and grandchildren or other older relatives – and, despite working abroad, to a certain extent



they remain responsible for in-family care and are still involved in the decision-making concerning it (Bauer and Österle 2016; Sekulová 2013a, 2015). Employing migrant care-givers from less-affluent countries – as depicted by the “care chain” concept – has not been found to be a significant strategy adopted by households in order to cope with care deficiencies resulting from the migration of their own family members (Bauer and Österle 2016; Búriková 2016; Sekulová 2013a).

In both Romania and Slovakia, families and care-givers mentioned some of the main challenges they face: their financial struggles due to the unsatisfactory system of cash benefits for the elderly and for the carers, the lack of available home-care services, exhaustion, and disappointment about the care pressure remaining on the shoulders of the families. Most of the care-givers involved in our sample experienced the need for institutional support with regard to care services. The families interviewed utilised public social care services to differing extents³⁴ – and some did not utilise any services, either because these were not available or the family was not interested (due to cultural attitudes or low trust in institutional services). However, they all considered the long-term care system as generally unsatisfactory and declared that they relied on the family’s care resources instead of searching for institutional support.

In Romania, the predominant concentration of long-term care on the shoulders of families is the result of its general framing – in which the state expects the major involvement of families in informal care. In Slovakia, the long-term care system is lacking any appropriate financial compensation for the loss of wages of those providing informal home care to family members. Diverse and accessible home-based care services are largely missing, and existing local-level services are under-developed in some localities, particularly in smaller municipalities. Our research indicates that, like the entire CEE region (Hirose and Czepulis-Rutkowska 2016), Romania and Slovakia lack adequate support mechanisms for home-based care, including home visits, day care, or stays in community-based long-term care facilities. Thus the burden of care is currently imposed mainly on family members. At present, countries are struggling to find alternatives to family care provision, as it is unlikely

³⁴ Those in our sample who utilised institutional services in our research localities were interested in the “meal-on-wheels” service and professional nursing assistance.



that families and other informal networks will be able to maintain their provision of at least similar amounts of informal care in the future (cf. Österle 2010).

4.3.5 Responses: institutional recognition and effects

In both Romania and Slovakia, care mobility is not recognised as significantly influencing long-term care (in either the institutional setting or at the level of the informal care provided within the family), nor that there might be a need for public policy development in the field. Consequently, there has been no visible implementation of any legislation or measure as a direct response to the crisis in care mobility yet.

However, other legislative developments in long-term care in the two countries, although not specifically focusing on care mobility, can be relevant. In Slovakia, the financial contribution for informal home-carers as compensation for their wage loss (the financial contribution is considered as a social benefit not as a wage) will increase from its current rate of around €250 to the minimum wage level until 2020 (Vanoch 2017). In Romania, the minimum income for inclusion developed in 2016 is being implemented as of April 2018, and comprises three types of social support: a guaranteed minimum income, financial benefits for poor families with children, and financial support for household expenses (particularly heating). While the minimum income for inclusion is linked to registration with the local employment agency, persons caring at home for children with disabilities or dependant elderly persons are exempt from this requirement. Consequently, increased social benefits may both attract some care-givers back to their origin countries and discourage others from going abroad – instead providing informal care in the home country.

4.4 Discussion

While the literature on the impact of parents' out-migration on their children's education (children who continue to reside in countries of origin) shows various and conflicting results (Arguillas and Williams 2010; Botezat and Pfeiffer 2014; Brown and Connell 2015; Giannelli and Mangiavacchi 2010; McKenzie and Rapoport 2011a), our research on the perceived impact of care work out-mobility from Romania and Slovakia on children's education



displays a more convergent picture. Nevertheless, some inconsistencies remain. On the one hand, local-level stakeholders – particularly school psychologists (in Slovakia) and teachers (in Romania) – whom we interviewed, all regarded care-work mobility as having a negative impact on educational attainment and child development. On the other hand, school psychologists and teachers exemplify this perception using extreme cases that include domestic violence or abuse, rather than a parent's migration only. These kinds of situations, although expressed as consequences of migration/mobility which in turn leads to poor performance in school, have multiple causes, and migration is only one aspect of an already difficult situation relating to alcoholism, domestic violence and poverty.

In both countries, there is little recognition, particularly at the level of national institutions, of the impact of care-work mobility on the education system and children's educational attainment. Although care work is acknowledged by Slovak national institutions as relevant for Slovak women and is linked with intra-EU mobility, it is not regarded as (negatively) impacting on the overall well-being of children for two main reasons. First, Slovak women working in care abroad are in their mid- or later life stage and have older children. Second, mobility patterns between Slovakia and Austria, for instance, allow these women to reconcile working abroad with their family life.

Local institutions reveal a different picture, demonstrating various understandings of the relevance of care mobility for the well-being of children with parents working abroad in care – well-being that includes educational attainment. In Romania, all the teachers interviewed for this research reported that the out-migration of the parents has a devastating effect on the children's school performance. Institutional responses to the effect of care mobility in the education sector aim at pedagogical and psychological counselling in schools as well as early-school-leaving prevention measures. They intend to address the effect that parents' out-migration (for various types of work) has on children who continue to reside in the sending country.

The perceived impacts of care mobility on the provision of health care in Romania and Slovakia are considered by both national- and local-level institutions in the context of labour-force shortages in the healthcare sector. These workforce shortages result from



unfavourable demographic structures, low numbers of educated professionals, and, increasingly, the emigration of trained professionals (Gurková *et al.* 2013; Radvanský and Dováľová 2013; Stachová 2008; Vladescu and Olsavsky 2009). Not only does care mobility challenge healthcare in Romania and Slovakia as it contributes to labour force shortages and therefore influences the quality of service provision, but it also represents an important challenge to the development of support services for the care-givers themselves. Care workers interviewed for this study underlined the negative impact which care work has on their own health due to the demanding nature of the work and the overall working conditions (24h/7 care work, live-ins etc.).

In Romania, the mobility of care workers is not perceived as having a particularly negative effect on the healthcare sector beyond the general perception of the negative effects of out-migration. Although, according to our academic respondents, care mobility contributes to existing labour shortages in Slovak healthcare, the return of nurses working abroad would not resolve the situation. Labour-force shortages in healthcare is not necessarily attributed to a lack of health workers with the required qualifications and skills, but to the reluctance of these people to work under the existing conditions in the Slovak healthcare system (OECD 2015a). In addition, the education system does not train the number of qualified members of the labour force currently needed within the healthcare sector, nor does it saturate the replacement demand (Radvanský and Lichner 2013).

Neither Romania nor Slovakia have taken specific steps towards incorporating care-work mobility into their policies on health care. Migration is not regarded as a priority for the healthcare system in Slovakia due to other significant structural problems in the sector. In Romania, the out-migration of medical doctors is considered to be one of the main negative aspects of mobility, as most work in other European countries, but care-migration for 24h/7 care is not regarded as a main issue.

Likewise, national stakeholders acknowledged the effects of care-work mobility in long-term care in relation to labour-force shortages, including interrelated aspects such as the lack of finances and the availability of, and access to, long-term care services. In both Romania and Slovakia, demand for care has increased due to an ageing population and changes in family



structure (responsible for informal home-based care). Both countries subscribe to a “familist/individualist” model of long-term care, whereby families and individuals hold the main responsibility for social care, while states provide limited financial support and formal care (in residential institutions). Due to cultural norms, informal care at home also seems to be the preferred and the main form of care provision in both countries.

Single-person elderly households, particularly in rural Slovakia, have been mentioned as one consequence of these changes within the family structure and represent a challenge for the “familist” long-term care model.

In addition to being female-dominated work, one main factor differentiating care-work mobility from other types of mobility relates to the special labour arrangements exemplified in this paper through the Austrian system and the recruitment agencies operating in both sending and receiving countries. The main issue reported by care workers with regard to labour arrangements related to the categorisation of care work in private homes as self-employment. The challenges reported covered the relationship between the family or dependent relative and the carer, the recruitment agency fees, and the general poor understanding by migrant workers of Austrian social security and fiscal systems. As most private home care in Austria is provided by self-employed carers – most of them migrants from other EU countries – the relationship between the person cared for or Austrian family and the carer is a business relationship and not an employer–employee one. The work being defined as “service provision” rather than as regular employment, Austrian labour law (e.g. working hours, paid leave/sick leave, collective bargain agreement, payment of taxes etc.) does not apply.

In addition, employing a care-mobility lens provides different perspectives on labour mobility in Europe. First, care provision is personal in the sense that it requires human connection (Hochschild 2003; Lutz 2007). While technology does change the nature of work in various domains, it can “facilitate coordination, improve quality of care and enhance efficiency” in long-term care (Tak, Benefield, and Mahoney 2010). Second, mobility patterns between countries geographically close to each other open up the analysis of employment conditions and employment regulations from different perspectives. In other words, this



perspective enables an analysis beyond what was previously known as “a *sedentarist* view on the organisation of social life” and prevents “simplistic territorialism” (Amelina 2017: 20).

Our research in the field of care mobility between Romania and Slovakia on one side and Austria on the other uncovered a few topics that need further exploration. One topic relates to the regulation of transportation of persons between these countries. As driving a vehicle with a capacity of transporting eight or fewer persons requires a valid driver’s licence only, and no other regulations seem to apply, accidents caused by the lack of safety measures have occurred. The other topic worth exploring relates to the *de facto* definition of personal home care in Austria as self-employment. This links the Austrian long-term care model to one of the four freedoms in the EU, namely the freedom of service provision in the European Union. Freedom of service provision allows the provision of personal home care by citizens of another EU member state as self-employment.³⁵ The informal provision of the same service by a third-country national (e.g. irregular employment of a third country national) would be considered illegal and fined accordingly.³⁶ However, in this case the care-giver would be fully protected by Austrian labour law and entitled to compensatory payment according to the minimum level of the collective agreement for care, including for example overtime and night-work compensation, even when returned to his/her country of origin. As so far no care-giver from another EU Member State has approached an Austrian court to decide about the applicability of labour law, care-givers from other European countries at present do not have comparable access to protection by Austrian labour law.

5 Conclusions

This paper has presented the perceived impacts of care mobility on education, health and long-term care systems in Romania and Slovakia through the example of care workers from these countries working in 24h/7 care in the private homes of elderly people in Austria. The

³⁵ This takes into account the requirement of self-employed care workers in Austria to have a minimum training in care provision. This training usually takes place in the sending country.

³⁶ Ukrainian domestic workers with responsibilities in care (Lutz 2016).



paper first introduced the topic of care work and the factors leading to an increased demand for care in European countries. It then went on to present the specificities of live-in 24h/7 care work in Austria. Further, the paper presented the perceived impacts and institutional responses to care-work mobility in three main areas – compulsory education, healthcare and long-term care.

In general, the results of this study show that, while labour mobility is considered relevant for the development of these three areas in Romania and Slovakia, labour mobility for care work is not seen as relevant, with a few exceptions. The main notable exception concerns the feminisation of this type of labour mobility, as it is mainly women who engage in care work. This is perceived, particularly by local-level stakeholders, to have a knock-on effect on the educational attainment of children whose mothers are employed abroad, on access to healthcare for dependent members of migrant families, and on the provision of quality long-term care for elderly family members. This is due to the long-term care systems employed in both of these countries – with relatively small differences – which are based on informal care provided by family members. National institutions present a different picture to that given by regional and local institutions, the latter perceiving care mobility as having more-negative effects. The main differentiating perception relates to out-migration which, in general, and care mobility in particular, has the negative effect of “leaving behind” dependent elderly relatives and children in need of parental supervision. At the same time, labour migration enabled these families to access quality services in at least two main areas – education and healthcare – through remittances.

Institutional responses to these challenges have not been framed as reactions to care-work mobility but as policy developments that address labour shortages or the care deficit in general. In Slovakia, the financial compensation for wage loss to informal home carers is expected to increase while, in Romania, the newly introduced minimum income for inclusion provides for preferential criteria for home-based carers of children with a disability or a dependant elderly relative.





6 References

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REMINDER

ROLE OF EUROPEAN MOBILITY AND ITS IMPACTS
IN NARRATIVES, DEBATES AND EU REFORMS

The REMINDER project is exploring the economic, social, institutional and policy factors that have shaped the impacts of free movement in the EU and public debates about it.

The project is coordinated from COMPAS and includes participation from 14 consortium partners in 9 countries across Europe



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