Care workers with migrant backgrounds in formal care services in Germany: A multi-level intersectional analysis

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ABSTRACT:
The restructuring of formal care services in Germany was followed by an increase in care workers with migrant backgrounds. Based on a survey-study in home-based and residential care his article compares the situation of care workers with and without migrant backgrounds. With its own conceptual framework of multi-level intersectional analysis, it examines the developments in care organisations embedded in long-term care, professionalisation, and migration policies. Most care workers with migrant backgrounds had permanent employment and residence permits. Those with skills in contrast to the unskilled, enjoyed favourable employment conditions, but both these groups faced difficulties in daily residential care work.

1 Introduction: Long-term care policy changes, marketisation, and the employment of migrant carers

Against a background of social changes – demographic change, increasing female labour market participation, and neo-liberal criticism of traditional welfare state arrangements – long-term care policies have undergone considerable restructurings in Western countries. The changes are characterised by the (re)-definition of long-term care rights, embedded within a newly-defined interplay of state, market and family, in care responsibilities. The latter concerns market-oriented restructurings of the formal care system and the introduction of different types of cash benefits, both to provide financial support for family care-giving and to facilitate the purchase of care services or assistance, including from outside the formal care system. The restructurings are based on (changing) cultural values but also aim to contain public costs in the context of demographic ageing (Ungerson and Yeandle, 2007; Williams and Brennan eds., 2012; Theobald, 2015).

Market-oriented restructurings of care work are often followed by an aggravation of care workers' employment and working situations within the formal care system, an emergence of private services or assistance within private households, often purchased on the grey market, and the increased employment of migrant care workers (see, e.g. Ungerson and Yeandle, 2007; Williams and Brennan eds. 2012; Theobald, 2012). The increased involvement of migrant care workers, both in formal care services and as a support or substitute for informal care provision within private households, has fostered a debate on the emergence of new social divisions based on migration status in this female-dominated activity and on its societal embeddedness (see, e.g. Lutz, 2008; Shutes and Chiatti, 2012; Williams and Brennan eds. 2012; Shutes, 2014).

The mode of integration of migrant care workers in the formal care system differs considerably between Western countries and between different forms of care work within each country. The first decisive element for the mode of integration is location, i.e., whether the integration of migrant care workers occurs within the formal care system and/or within the household context, and how each is embedded within (country-specific) long term care, employment, and migration policies (Simonazzi, 2009). Second, migration policies regulate access to (distinct areas of) the labour market, define labour market status for distinct groups among migrants, and thus influence labour market opportunities, behaviour and experiences (van Hooren, 2014). Third, the mode of care worker integration is influenced by prevailing employment and professionalisation policies, which define employment conditions, professional approaches, and qualification standards in care work (Simonazzi, 2009; Theobald, 2011; Williams, 2012). Regarding the location of migrant care work, three different systems can be distinguished: one with an emphasis on migrant care workers within formal care systems (e.g. in the Northern European countries); one with an emphasis on employment within private households (e.g. in the Mediterranean European countries and some South-East Asian countries); and one with a wide range of mixed countries (e.g. Germany, Austria, Canada, and the UK).

Research findings have shown different patterns of integration for migrant care workers and interrelated systematic disparities related to the work, employment, and caring situation between migrant and non-migrant care workers in the formal care system in Western countries. In Sweden and Denmark, migrant care workers have access to regular care work based on employment-related social rights, with only limited evidence of systematic disparities. In Sweden, patterns of precarious employment situations have been found for care workers independent of migration status (Rostgaard et al, 2011; Jönson and Giertz, 2013). Regional-based research in Germany on the skill levels of care workers with migration backgrounds in residential care services has found comparable skill levels between care workers with and without migration backgrounds. (In Germany the term 'migration background' is used because care workers who are foreign-born, or who are second-generation migrants, with at least one foreign-born parent, are included in research studies; for an overview, see Stagge, 2016).

For the UK, research has revealed strong indicators for systematic disparities, e.g. migrant care workers are more highly concentrated in lower-paid and less-secure types of care work; migrant care workers report working overtime more often, being rostered for less-favourable shifts compared with 'English' care workers, and taking on extra tasks (such as cleaning) during staff shortages. The emergence of systematic disparities is explained by the establishment of a strongly marketised formal care system, and its interplay with migration

regulations (Shutes and Chiatti, 2012; Shutes, 2014).

In a qualitative study with migrant care workers in Ireland, Doyle and Timonen (2009) also found indicators for exploitative work practices; however, the experience of discrimination was different for different groups of migrant care workers and was linked to their country of origin. Much of the experience of discrimination seems to be rooted in migration policies, especially the use of conditional residence permits, which makes care workers dependent on their employers. In contrast, with a sample of regular and unionised care workers in the formal care system in one province of Canada, Martin-Matthews et al (2010) revealed many similarities and differences between Canadian and foreign-born care workers and only few differences between migrant care workers with different countries of origin. Despite indications of discrimination against migrant care workers (e.g. small but significant wage differences), they were not systematically disadvantaged.

There is evidence too that further factors contribute to systematic disparities, in particular in daily care work. In a large qualitative study in the UK, Hussein et al (2010) found indicators for discrimination based on racism, particularly within social interactions with users and, more rarely, in social interactions with colleagues and managers (see also Doyle and Timonen, 2009 for Ireland). In a large qualitative study in Canada, Bourgeault et al (2010) revealed that language difficulties and cultural differences between care users and care workers can have a significant influence on users' perceptions of migrant care workers' ability to offer adequate care, and consequently on their relationship with them. Qualitative interview studies with small samples also confirm difficulties for care workers with migrant backgrounds in Germany regarding cooperation with colleagues and, more rarely, in social interactions with care users or their families, which may be based on language difficulties and cultural differences (Buchinger, 2013; Stagge, 2016). For the UK, Shutes (2014) stated that the extra tasks conducted by migrant care workers limit the time needed to develop care relationships with care users and shape care workers' experience of poor quality working conditions. Martin-Matthews et al (2010) found evidence of 'hostility' between co-workers and strong evidence of hostility from care users; however, this was reported by both Canadian and foreign-born care workers. 'Hostility' is based on a (perceived) lack of understanding of (or respect for) the cultural preferences of the users, independent of migration status.

The research findings in different Western countries reveal that systematic disparities between care workers can exist in aspects of the employment, working, and caring situation, based on migration status; however, these disparities are embedded in country differences. Country differences are influenced by long-term care policies, employment or professionalisation policies (i.e. definition of employment conditions, professional approaches, and qualification standards in care work) and migration policies (i.e. care

workers' distinct migration status). Besides social policies, research findings also indicate that prejudice, cultural differences, language difficulties, and work organisation in daily care work can have an influence (as a basis for the development of systematic disparities).

This article analyses patterns of integration for care workers with migration backgrounds in the formal care system in Germany, with a focus on the prevalence of systematic disparities within the employment, work, and caring situation between care workers with and without migration backgrounds. Beyond migration status, skill levels, which are significant for the development of systematic disparities in the formal care system in Germany, are also included in the comparison (TNS Infratest Sozialforschung, 2011; Theobald et al, 2013). The article is organised as follows: in Section 2, a multi-level intersectional conceptual approach is developed. This is used to analyse which factors influence the development of systematic disparities, and how these factors influence their development, and how these factors interact with social policies. In the subsequent empirical parts, first, the German long-term care system and the development of the formal care system are presented (Section 3), and second, using data from the author's large survey of care workers in home-based and residential care provision in Germany, the situation of care workers with and without migration backgrounds is compared (Section 4). In the conclusion, the empirical findings are discussed, embedded in the conceptual framework and international research findings.

2 Conceptual framework: A multi-level intersectional approach

Multi-level intersectional approaches provide conceptual tools to analyse the development of systematic disparities based on the intersection of migration status and skill levels in the course of the integration of care workers with migrant backgrounds in formal care provision in Germany. Intersectional approaches are based on the assumption that different types of inequalities, and their intersection, are socially constructed within a distinct social context. Multi-level intersectional analysis considers the processes of social construction at macro-, meso-, and micro-levels and their interrelationships (see e.g. Becker-Schmidt, 2007).

At macro-levels, social policies are viewed as one significant factor that influences the construction of the intersection of inequalities in social contexts. Based on empirical findings in this area, a twofold impact of social policies can be defined. First, mode of public support and extent of marketisation (in long-term care), as well as policies on employment and professionalisation, impact on the construction of the formal care system (Simonazzi, 2009; Theobald, 2011; Williams, 2012); and second, in the formal care system, social policies influence how different groups of care workers are allocated to roles, and their position within

status hierarchies. In her framework for analysing how social policies affect this process Daly's (2000) sees their interaction with inequalities between care workers as an important starting point. For her analysis, Daly (2000) distinguished between processes, structures, and outcomes. She identified the construction of care activities across the private-public border (i.e. as informal and formal care provision and the interrelated conditions of care work) as a fundamental societal process within social care. The development of this process is embedded in structures (i.e. social policy approaches related to care work). As outcomes, Daly (2000) described systematic disparities and related processes of allocation and hierarchisation between different groups of carers, arising from different types of inequalities and their intersection.

Daly's (2000) approach emphasises the interrelationship between social policies and the construction of care work. It also describes relevant outcomes, but does not provide tools for a systematic analysis of the development of these outcomes. Becker-Schmidt's (2007) assumptions about the impact of social policies on the construction of the intersection of inequalities provide the first conceptual basis for extending Daly's analysis. Becker-Schmidt (2007) deemed processes of status allocation (in which part of the population is assigned a certain status or position in society, regardless of individual situations) to be decisive for the development of processes of hierarchisation between minority or majority populations. Social policies contribute significantly to these processes.

While Becker-Schmidt (2007) considered the macro-level, Acker's (2006) approach to inequality regimes focused on construction processes within work organisations. According to Acker, all work organisations have inequality regimes 'defined as loosely interrelated practices, processes, actions, and meanings that result in and maintain social class, gender, and racial inequalities within particular organisations' (Acker, 2006:443). Acker relates inequality in organisations to a wide range of systematic disparities between participants, based on prevailing employment conditions and aspects of the work situation, as well as on respect and on pleasure derived from work and work relations. Organisations vary in the degree to which these disparities are present and how severe they are, whether they are viewed as legitimised (e.g. because of training or performance criteria), and in their degree of awareness of unequal practices or processes. Based on her research, Acker (2006) summarised several significant practices responsible for the development of systematic disparities and the related intersection of inequalities. These range from the definition of employment and working conditions (e.g. working-time arrangements, job descriptions embedded in organisational hierarchies, and recruitment and hiring) to supervisory practices and social interactions while 'doing the work'.

The approaches outlined provide general conceptual tools for the analysis of the intersection of inequalities based on systematic disparities within work organisations embedded in social policies. These approaches have to be specified according to the intended empirical analysis of the integration of care workers with migration backgrounds in the formal care system in Germany. Empirical findings on migrant care workers' patterns of integration into the formal care system have revealed that distinct aspects of the employment situation, work organisation and practices, and social interactions with care users and colleagues, are significant areas in which systematic disparities emerge. They also indicate that in care organisations they can be the basis for structures of inequalities based on migration status. In the following empirical analysis, these areas are analysed within their respective social policy approaches in Germany, as is their significance for how the formal care system is constructed and for how different groups of care workers dependent on migration status and skill levels are allocated to roles within its hierarchies.

3 The development of the formal care system in Germany

In this section, care arrangements, their mix of formal and informal care work, and the development of the formal care system in Germany, are presented. The role of long-term care and professionalisation policies in shaping Germany's formal care system is also examined. When Long-term Care Insurance (LTCI) was introduced in 1995/96, long-term policies were considerably restructured. The system changed from a residual approach, defined by the law on 'Assistance to Long-Term Care' that granted means-tested benefits in a situation of frailty, to a universal-oriented system (LTCI) that provided capped lump-sum benefits at clearly-defined levels of care dependency for the whole population, and offered beneficiaries a choice between an unregulated cash payment to support care provision within the family framework, or service benefits to purchase home-based care and (semi)-residential care services delivered by providers registered in the LTCI system. With benefits capped, the private costs of using formal care services within the LTCI framework amount to 33% of total costs, while public spending on long-term care support for older people is - compared with other OECD countries - only at a medium level (equal to 1.0% of GDP in 2013 for the social and healthcare component) (Rothgang, 2010; OECD, 2015).

Alongside the universalisation of public support, the law on LTCI stipulated the introduction of a regulated care market as the basis for expansion of the formal care system. The approaches used were oriented towards New Public Management reforms, based on ideas

about the role of market competition, customer choice, and contract management. A regulated care market was created, based on equal competition for care prices and care quality, between the formerly privileged and quantitatively dominant non-profit- and for-profit providers and the only rare public providers available in residential care. In line with the customer choice model, beneficiaries may choose freely among registered providers and care offers. At a regional level, long-term care insurance funds register providers based on certain preconditions – qualification requirements, cost effectiveness, availability of internal quality-management measures – and negotiate offers, prices and quality management with the provider (organisations) specified in a contract.

Within this policy framework, a family-based care strategy has emerged that is characterised by a considerable share of family care provision, supported only by unregulated cash payments. In 2015, 33% of beneficiaries living at home used home-based care services from registered care providers based on service benefits and private means (Federal Statistical Office, 2017). These arrangements are complemented by regular or occasional assistance or services purchased outside the framework of LTCI and based on unregulated cash benefits or private means. Since 2000, a new type of support has emerged with the provision of comprehensive 24-hour care within private households by live-in migrant care workers. According to the most recent estimates, 300,000 to 400,000 migrant live-in care workers are employed within private households (Satola and Schywalski, 2016). This can be compared with 1,085,758 (full-time equivalent: 764,051) care workers employed in the formal care system within the LTCI framework in 2015 (Federal Statistical Office, 2017).

Despite the family orientation (i.e. informal family care provision and 24-hour care provision within the family framework), within the framework of LTCI the formal care system has significantly expanded,. With the expansion of home-based care service providers (from 4,000 in 1993 to 13,323 in 2015), the share of for-profit providers rose considerably (reaching 65% of providers and 50% of service users in 2015) in a formerly predominantly non-profit care infrastructure. The increase of for-profit residential care facilities was less pronounced. In 2015, non-profit providers there still cover about 53% of residential facilities and 56% of beds and public providers in addition about 5% of the facilities and 6% of beds (Schölkopf, 1998: Slotala, 2011; Federal Statistical Office, 2017).

Expansion and marketisation (i.e. competition in a care market, the growth of for-profit providers, and the emphasis on cost effectiveness in contract negotiations) has had a strong impact on the employment of care workers. Between 1993 and 2015, the number of care workers in home-based care services increased from 49,808 to 355,613 (full-time equivalent

in 2015: 238,846), and in residential care services, from 174,051 to 730,145 (full-time equivalent in 2015: 525,205). The new jobs were largely part-time; with the rate of part-time work increasing between 1993 and 2015 from 46.0% to 72.8% in home-based care, and from 35.3% to 68.8% in residential care. Some care workers were even employed with contracts at lower social security standards (the share in 2015 being 20.0% in home-based care and 9.2% in residential care) (Schölkopf, 1998; Federal Statistical Office, 2017). In Germany, part-time contracts at lower social security standards are allowed for employment contracts with wages up to €450 per month or for short-term employment (up to 3 months and no more than 70 days per year). These contracts do not include statutory health care insurance, long-term care insurance, or unemployment insurance. Statutory pension insurance schemes are included, but can be declined by employees if they choose. These contracts are particularly widespread among care workers without formal care training qualifications, who mainly provide household services in home-based care provision (TNS Infratest Sozialforschung, 2011).

The expansion of employment arose from recruitment of both skilled workers (i.e. primarily those who have completed a three-year occupational training programme as a nurse or elder carer) and staff with lower levels of skill (i.e. either without a formal care training qualification or care assistants, who have undertaken an occupational training programme of up to one year). The proportion of care workers with lower skill levels was 44.3% in home-based care services and 55% in residential care services in 2015. This skill mix is the outcome of a professionalisation approach in care work (i.e. with an emphasis on programmes providing three years of occupational training), the definition of qualification standards, and the mode of service provision. Within residential care services, a 50% quota of skilled staff is stipulated by law. In home-based care, qualification standards are an outcome of the integrated delivery of long-term care and home nursing services, in which the provision of the latter (only) requires skilled staff.

The marketisation of the formal care system is visible in the increased proportion of care workers employed by for-profit providers, which rose from 35.5% in 1999 to 56.2% in 2015 in home-based care, and from 23.7% in 1999 to 35.3% in 2015 in residential care (own calculations, based on Federal Statistical Office, 2001, 2017). Employment conditions (skill levels, working-time arrangements) were very similar in for- non-profit and public providers. The only exception was the proportion of part-time work on lower social security standards in residential care services, which was 11.2% among care workers in the for-profit sector, 8.4% in the non-profit sector and 5.6% in the public sector (own calculations, based on Federal Statistical Office, 2017). Furthermore, research findings revealed a reduction of wage levels

for unskilled or assistant staff in for- and non-profit provision. The similarities are the *result* of a convergence between non-, for-profit and/or public sectors due to the emphasis on cost effectiveness in contract negotiation and on price competition in the care market (Slotala, 2011; Maurer, 2015).

4 The integration of care workers with migration backgrounds

Findings from a large survey of care workers within home-based and residential care provision in Germany are used to examine patterns of integration for care workers with migration backgrounds in the formal care system, with a focus on the development of systematic disparities. First, the impact of migration policies on the migration status of the survey participants with migration backgrounds is shown, with a description of the sample.

4.1 Empirical approach, sampling, and sample

The survey of care workers in home-based and residential care provision conducted in Germany in 2010 used the questionnaire developed for the 'Nordcare-project' on the situation of care workers in the Nordic countries in 2005 coordinated by Prof. Martha Szebehely, Stockholm`s University.[1] It covers a broad range of questions on individuals' employment and working situations, as well as on how employment and family responsibilities are combined, and contains mainly closed questions (with 4-5 optional answers) plus some open questions in which participants could provide their own answers. The German sampling was performed in a two-step approach: First, a stratified, systematic cluster sample of residential and home-based care providers was selected (criteria: providers of different sizes, with a distribution throughout the whole country) from a register comprising all for-profit and non-profit providers in Germany, complemented by randomly selected public providers in residential care provision. Second, providers were asked to distribute questionnaires to all the care workers they employed, which the workers completed and returned directly to the university. The survey questionnaire was distributed to a sample of 1,517 care workers in home-based and residential care provision, achieving a response rate of 43%. In total, 637 questionnaires could be included in the data analysis, which was based on descriptive comparisons (cross-tabulations and chi-squared tests) using SPSS. Due to language difficulties, particularly care worker with migration backgrounds and lower skill levels may be underrepresented.

[1] I would like to thank the Hans-Böckler Foundation, Düsseldorf Germany for the financing of two research projects related to this survey in Germany.

The sample confirmed care work to be a female-dominated activity (90% and higher among participants), independent of sector and migration backgrounds. It also found that 10.2% of participants in home-based care, and 14.0% of participants in residential care, had a migration background. In home-based care, this was very similar to an estimate (11%) based on a representative enquiry sent to managers in 2010. The proportion of care workers with a migration background in residential care provision (14.0%) was a little low compared with a representative enquiry with managerial staff at different levels in 2010, which estimated the proportion of care workers with migration backgrounds to be between 15% and 23% (for the estimates, see TNS Infratest Sozialforschung, 2011). The term ‘migration backgrounds’ in this sample includes foreign-born and second generation (at least one foreign-born parent) care workers; this definition was also used in the aforementioned representative enquiry.

In our study, about 79% of care workers with migration backgrounds were foreign-born, and 21% were second-generation migrants. About two thirds of care workers with migration backgrounds came from Russia, Poland, and Kazakhstan (59.5%) and other Eastern European countries (6.3%). Most care workers from Russia and Kazakhstan were foreign-born (92.1%), while among those of Polish origin, 28.6% were second-generation migrants. The remaining third came from European countries (17.7% including Italy, Greece, France, the Netherlands, Croatia, and Bosnia) and countries outside Europe (16.5% including the Philippines, Korea, Columbia and Turkey).

In Germany, care workers from Eastern European countries, and those from Russia and Kazakhstan, can be assumed to belong to the migration group of ‘(Spät)Aussiedler’, i.e. ‘ethnic Germans’ or migrants with German ancestors who live in the former Soviet Union or in Eastern European countries. Based on a general assumption of persecution (or at least a disadvantaged situation) in their country of origin due to their German roots, and as stipulated by constitutional law after World War II, these ‘ethnic Germans’ were allowed to emigrate back to the Federal Republic of Germany. Although the regulations demand the evidence of some German language skills, the knowledge of German language declined in the course of the 1990s. As ‘ethnic Germans’, they had access to German citizenship status and thus equal access to the labour market. Between 1950 and 2012, 4.5 million (Spät)Aussiedler emigrated to the Federal Republic of Germany, of which 2.5 million people came after 1990. Before 1990, these emigrants’ countries of origin were mainly Poland and Romania (60%), but since the 1990s, Russia and Kazakhstan were the main countries of origin, together representing 80% of the (Spät)Aussiedler in this period. After 2006, the number dropped drastically (Worbs et al, 2013). Based on their migration backgrounds, the majority of care workers in the sample (in which “Spätaussiedler”, care workers from western European countries and second-generation migrants were quantitatively dominant) can be

assumed to rely on stable residence- and work permits.

4.2 Care workers with migration backgrounds: Patterns of integration and systematic disparities

In this section, patterns of integration into the formal care system for care workers with (with MB) and without (no MB) migration backgrounds are compared, based on the findings of the survey, with a focus on the development of systematic disparities. According to the conceptual framework, systematic disparities may be related to aspects of the employment situation, work organisation and practices and social interactions (see Section 2). At first, significant indicators of the *employment situation* (skill levels and working-time arrangements) appear to paint a positive picture of the patterns of integration of care workers with migration backgrounds (see Table 1 in the attachment). With regard to skill levels, care workers with migration backgrounds are more likely (albeit not significantly) to be well qualified (i.e. to have completed an accredited, usually three-year, occupational training programme as a nurse or elder carer), than care workers without migration backgrounds. This corresponds to available findings of regional studies in residential care services, which report comparable skill levels (see Section 1). The similar skill levels among both groups of care workers can be explained by the demand for skilled care workers (mainly nurses and elder carers) which arises from regulations on qualification standards and corresponding professionalisation approaches (see Section 3), and the promotion of these through active labour market policies, offering training opportunities relevant to eldercare work, designed to facilitate labour market participation (see Stagge, 2016).

The slightly higher proportion of skilled carers with migration backgrounds in our findings may reflect sampling difficulties (see section 4.1). Wage levels in Germany depend on skill levels and sector (i.e. skilled staff and care workers in residential care services enjoy higher wage levels than those in home-based services) (Bogai et al, 2016). Neither indicator (skill levels or – more often – employment in the residential care sector, independent of skill levels) places care workers with migration backgrounds in a disadvantaged situation. However, despite their lower wage levels, care workers in Germany are generally more satisfied when they work in home-based care (Theobald et al, 2013).

Nor, at first glance, do working-time arrangements reflect systematic disparities or a disadvantaged position of care workers with migration backgrounds. Indeed, the latter are employed on full-time working contracts much more often (in both home-based and residential care services) and less often on either long or short (and often precarious) part-

time arrangements (see Table 2 in the attachment). A more detailed analysis of involvement in short part-time arrangements reveals a complex interplay of skill levels, family model and migration status. however. In general, care workers without migration backgrounds are more often employed on short part-time contracts (17.2% versus 9.5%). This can be explained by their more widespread combination of responsibilities for children up to 18 years and employment on short part-time contracts (23.1% versus 6.7%). In contrast, care workers with migrant backgrounds and without formal care training qualification are more often employed based on this type of contract (23.5% versus 15.0%). This indicator for a disadvantaged situation of care workers with migration backgrounds and without formal care training qualifications, may even be an underestimate, due to sampling difficulties. The data also reveal a sectorial divide, that is, care workers with migration backgrounds and without formal care training qualifications are more often employed in residential care services and those without migration background more often work in home-based care services.

The more widespread employment of care workers without formal care training qualifications and with migrant backgrounds in short part-time hours jobs in residential care services is a first indicator of their disadvantaged situation in this sector. When several aspects of *work organisation and practices* are analysed, systematic disparities became visible in residential care provision for care workers with migrant backgrounds. The first issue concerns the distribution of overtime work (see Table 3 in the attachment). While there is no difference regarding paid overtime, care workers with migration backgrounds are much more likely to report undertaking unpaid overtime (at least once a week: 40.9% versus 18.3%). Their situation is further aggravated when the differences between both groups [for care workers without formal care training qualifications (73.3% versus 20.5%) and with short part-time contracts (100% versus 30.3%)] are compared.

A second issue concerns the distribution of work tasks (Table 3 in the attachment). In Germany, all care workers independent of skill levels and migration status are conducting bodily care work to a strong extent, which is combined by nurses and elder carers with nursing care activities. However, in addition to these tasks, care workers with migration backgrounds clean residents' rooms more often, a task considered low-status work in the German system. The difference is most pronounced for care workers without formal care training qualifications, among whom 50.0% of those with migration backgrounds clean a resident's room on a daily basis, compared with only 14.2% of other unqualified care workers.

A third issue concerns cooperation with colleagues and intermediate supervisors. Despite their generally positive assessment (most care workers with migration backgrounds felt appreciated by colleagues and intermediary supervisors; (not shown in the table), some

answers reveal systematic disparities (see Table 4 in the attachment). Thus care workers with migration backgrounds reported having significantly less ‘time to discuss difficulties in their work with colleagues’ (the highest level: 14.6%, compared with 34.2% of those without migrant background). A more detailed analysis based on skill levels reveals that this concerns all care workers with migration backgrounds with the exception of the nurses Furthermore, care workers with migration backgrounds (independent of skill level) report meetings between the immediate supervisor and staff less often (only 13.6% reported having daily meetings, compared with 37.0% of those without migrant background).

Finally, systematic disparities for care workers with migration backgrounds can be found in their *social interactions with residents and their families* (see Table 5 in the attachment). Care workers with migration backgrounds feel significantly less than other care workers that their work is appreciated by care recipients’ close kin (only 10.9%, versus 28.9% of those without migrant background, responded ‘yes, a lot’ to this question); more of them (almost significantly [> 0.06]) claim to be criticised nearly every day by residents or their relatives (10.4% versus 3.4%), they feel they are subjected to physical violence significantly more often (every day: 20.4% versus 7.6%), and they report xenophobic comments significantly more often (every week: 14.9% versus 4.6%). Although there are substantial groups among care workers with migration backgrounds who rarely or never experience these situations (e.g. 69.4% report no, or rare, physical violence and 78.7% do rarely or never experience xenophobic comments), the number of indicators and the significant differences reveal considerably difficult social interactions. These difficult social interactions appear independent of skill levels, but the country of origin seems to play a significant role. In the study, only foreign care workers from Russia, Kazakhstan and Poland reported having been criticised, or having been subjected to physical violence daily. Xenophobic comments on a weekly basis were reported by foreign care workers from Poland and Russia and by second-generation migrant care workers from the former Yugoslavia.

5 Conclusion: The emergence of a new division of inequality in a complex interplay of migration status and skill levels

This article has analysed the patterns of integration of care workers with migration backgrounds in care organisations in Germany, embedding the analysis in a multi-level intersectional approach. Empirically, it is based on the author’s own large and comprehensive survey study of care workers in home-based and residential care provision throughout Germany. This, the first large and comprehensive survey study in Germany on this topic, provides a baseline measurement that can serve as a point of comparison with subsequent developments. In the conclusion, the findings of the study - embedded in the

main features of the conceptual framework, with its focus on the emergence of systematic disparities based on migration status and skill levels in care organisations - and how these are shaped by social policies, are discussed.

Embedded in long-term care and professionalisation policies, the German formal care system has been expanded and restructured, with an increase in the use of part-time work arrangements and of both skilled and unskilled staff. Care workers with migration backgrounds, who are increasingly employed, mainly draw on permanent work and residence permits, and among them the largest group ('Spätaussiedler', or 'ethnic Germans') can even obtain German citizenship, which provides equal access to the labour market and training opportunities.

Against this background, systematic disparities based on migration status emerge in a complex mix of skill levels and sectors, while (due the convergence of for- and non-profit provision) the type of agency which employs them is not relevant. The employment situation, i.e. skill levels and working-time arrangements for skilled carers (about 50% of care workers) reveals an equal situation for care workers with and without migration backgrounds. This can be explained by the interaction of professionalisation policies and the implementation of qualifications standards in care work, which have resulted in demand for skilled care workers, and migration policies, i.e. stable residence and work permits, which offer access to care-related training. Unskilled care workers, however, are more often allocated to short part-time, and often precarious, work arrangements, a situation which is particularly acute for care workers with migrant backgrounds in residential care services.

In residential care services, further systematic disparities emerge for all care workers with migrant backgrounds, interrelated to skill levels – regarding aspects of work organisation and practices as well as social interactions. While low skill levels strengthen the negative effects of migration status regarding aspects of work organisation and practices, only migration status is relevant for social interactions with residents and families. Care workers from Eastern European countries are particularly disadvantaged regarding social interactions.

The findings of the survey study reveal the emergence of migration status as a new inequality division in residential care services in Germany, and display its complex interaction with skill levels and its embeddedness in social policy approaches. Compared with international research, the study findings regarding the employment situation appear to be country-specific and based on an interplay of distinct professionalisation and migration policies in Germany. Related to aspects of work organisation and practices, as well as to

social interactions, in residential care services, the research findings resemble findings in other Western countries, particularly the UK (see Hussein et al (2010); Shutes, 2014). This indicates that not only country-specific long-term care, professionalization and migration policies, but also other factors (such as work organisation, cultural difference, language difficulties and prejudice) play a role in structuring inequalities in care work (see Section 1).

Since the survey study was conducted in 2010, migration and long term care policies in Germany have been altered, in developments which may affect future patterns of integration of care workers with migration backgrounds. Care workers with migration backgrounds in our study were mainly recruited among foreign-born and second-generation migrants already living in the country. Before 2010, only with Kroatia and Slovenia an agreement for recruitment to Germany was in place with 2,547 skilled care workers or nurses recruited between 1996-2012 (Neukirch, 2015). International recruitment of care workers on larger scale began only after 2010, based on initiatives of the state and changes to the legal arrangements for international employment and recruitment. Germany only opened its labour market to citizens of the new EU member states in central and Eastern Europe in 2011 and 2014, respectively. The 2013 reform of the Beschäftigungsverordnung (Employment Regulation) enabled employers to recruit skilled personnel with vocational training in occupations with staff shortages internationally, including nurses and skilled personnel in elder care. Subsequent research on international recruitment reveals that for-profit residential care providers are most often actively recruiting skilled care workers mainly in the new and older EU member states (Braeseke and Bonin, 2016). According to our study findings, skill levels and a stable work and residence permit, due to citizenship in an EU member state, will promote an equal employment situation. In contrast, the emergence of systematic disparities in work organisation and social interactions for care workers from the new EU member states may be strengthened due to country-specific occupational training programmes.

With the most recent LTCI reform, the Act on Strengthening Long-term Care 1-3 (2015-2017), home-based care services will now also be expanded to include increasingly social activities, surveillance (for example supervision and monitoring) and household services, which (the law now suggests) should be provided by voluntary workers, care aides, and assistants. The trend towards precarity in home-based care services will thus be strengthened, a trend which may increasingly include, and be even more pronounced for, care workers with migration backgrounds.

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Attachment

Table 1 Care workers by migrant background status, level of skill and sector of employment

	Home-based care			Residential care			All care work		
	With MB	No MB	All	With MB	No MB	All	With MB	No MB	All
High skilled	76.5	50.6	53.1	39.6	31.4	32.5	49.2	37.2	38.6
Lower skilled	5.9	15.2	14.3	18.7	15.3	15.8	15.4	15.2	15.3
Unskilled	17.6	34.2	32.5	41.7	53.2	51.8	35.4	47.5	46.1
Total	100	100	100	100	100	100	100	100	100
N=	17	158	175	48	359	407	65	517	582

Note: With MB= care workers with migrant backgrounds; No MB= care workers without migrant background[1]
Some column totals may not = exactly 100 because of rounding
High skilled: elder carers, nurses; Lower skilled: additional skilled staff; Unskilled: assistants, without formal care training

Table 2 Care workers by migrant background status, working time arrangement and level of skill

%

Working time arrangement	**Home-based care all**			**Home-based care *Workers without formal care training****			**Residential care** all**			**Residential care** *Workers without formal care training****			**ALL care workers**			***All care workers without formal care training***		
	With MB	**No MB**	**All**	**With MB**	**No MB**	**All**	**With MB**	**No MB**	**All**	**With MB**	**No MB**	**All**	**With MB**	**No MB**	**All**	**With MB**	**No MB**	**All**
Full-Time (35+ hrs p w)	47.1	26.6	28.7	50.0	17.1	18.6	67.4	44.4	47.0	46.7	33.9	35.0	**61.9**	**39.1**	**41.6**	**47.1**	**30.6**	**31.8**
Long Part-Time (21-34 hrs p w)	41.2	41.6	41.5	50.0	41.4	41.9	23.9	44.7	42.3	26.7	57.6	55.0	**28.6**	**43.6**	**42.0**	**29.4**	**54.4**	**52.5**
Short Part-Time (<21 hrs p w)	11.8	31.8	29.8	0.0	41.5	39.5	8.7	10.9	10.6	26.7	8.5	10.0	**9.5**	**17.2**	**16.4**	**23.5**	**15.0**	**15.7**
All[1]	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Notes: *p<0.05; **p<0.01 (chi-squared tests); With MB = care workers with migrant backgrounds; No MB= care workers without migrant background
[1] Some column totals may not = exactly 100 because of rounding

Table 3 Residential care workers by work organisation and practices

%

Activity	Frequency		
Working unpaid overtime	**At least once a week**	**More rarely** (monthly, rarely, never)	All
All care workers**			
With migrant background	40.9	59.1	100
Without migrant background	18.3	81.7	100
Care workers without formal care training**			
With migrant background	73.3	26.7	100
Without migrant background	20.5	79.5	100
Care workers employed on short part-time hours**			
With migrant background	100.0	0.0	100
Without migrant background	30.3	69.7	100
Cleaning a care recipient's home / room	**Daily / several times a day**	**More rarely** (weekly, monthly, rarely, never)	
All care workers**			
With migrant background	31.8	68.2	100
Without migrant background	14.6	85.4	100
Without formal care training**			
With migrant background	50.0	50.0	100
Without migrant background	14.2	85.8	100

Notes: **$p<0.01$ (chi-squared tests).
1 Some row totals may not = exactly 100 because of rounding

Table 4 Residential care workers by supervisory and consultation arrangements

%

Supervisory/consultation arrangement	**Frequency**			
At your workplace, how often are there meetings between the staff and your closest supervisor?	Every day	Every week	More rarely (monthly or less often)	All
All care workers**				
With migrant background	13.6	47.7	38.6	100
Without migrant background	37.0	16.2	46.7	100
Do you have enough time to discuss difficulties in your work with your colleagues?	Yes, most often	Sometimes	Rarely / never	
All care workers**				
With migrant background	14.6	58.3	27.1	100
Without migrant background	34.2	40.3	25.6	100

Note: **p<0.01 (chi-squared tests);

1 Some row totals may not = exactly 100 because of rounding

Table 5 Care workers in residential care: social interactions with residents / families

%

Type of interaction	Frequency				
	Yes, a lot	***Yes, somewhat***	***No, rather little***	***No, not at all***	**ALL**
Do you find your work is appreciated by the care recipient's close kin? *					
With migrant background	10.9	65.2	23.9	0	100
Without migrant background	28.9	56.5	14.3	0.3	100
	Every day	***Every week***	***Every month***	***Rarely / never***	
How often do you get criticised or told off by a care recipient or her/his relative?					
With migrant background	10.4	14.6	12.5	62.6	100
Without migrant background	3.4	9.0	9.6	78.0	100
How often are you subjected to physical violence? **					
With migrant background	20.4	6.1	4.1	69.4	100
Without migrant background	7.6	15.3	7.6	69.4	100
How often do you face xenophobic comments made by a care recipient or his/her relative? **					
With migrant background	0	14.9	6.4	78.7	100
Without migrant background	0	4.6	2.0	93.5	100

Notes: *p<0.05; **p<0.01 (chi-squared tests);
[1] Some row totals may not = exactly 100 because of rounding