Migrant care workers needed urgently.
Explaining the migrantization of the long-term care workforce and its policy implications using causal chains

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Abstract

Due to a combination of demographic and societal factors, the demand for care is intensifying across Europe. In many countries, including Germany, this demand is increasingly fulfilled by hiring migrant care workers. The article identifies the causes explaining the increasing reliance of the German long-term care (LTC) system on a migrant workforce. Furthermore, the article examines the (in)adequacy of recent LTC reforms with the increasing migrantization of LTC provision. This migrantization manifests in two ways: on the one hand, the spread of home-based elderly care provision by migrant workers, resulting in the emergence of a 'migrant in the family' model of care (A), on the other, the increasing share of migrants in formal care settings, leading to the development of a 'migrant in formal care' model of care (B).

We identified causal process tracing as the optimal method to explain both outcomes. Process tracing establishes causal chains, which break down the causal explanation of an outcome into a series of smaller successive steps connected by causal mechanisms. We followed authors for whom process tracing starts from the reconstruction of a chronology, subsequently transformed into a causal chain. The two causal chains identified in this article show macro change as produced by interactions between the macro level of policies and structures, and the micro level of individuals and households.

We show that the migrantization of care in Germany has been triggered by the combination of two features of LTC insurance (cash benefits and provider competition) with the readily available supply of a migrant workforce from Central and Eastern Europe (CEE). A product of the post-1989 transformation of CEE, these migrant flows have been accelerated and facilitated by EU integration.

From the demand side, migrantization raises the question of the current and future sustainability of the German LTC system. From the supply side, the increased demand for migrant care workers in Germany contributes to emerging care gaps in the countries from which migrants originate. These gaps in turn stimulate the formation of transnational care chains, such as the one already linking Germany to Poland and Poland to Ukraine. Indeed, while the biggest share of migrant care

workers in Germany originates from Poland, families in Poland's bigger cities are now increasingly hiring live-in care providers from Ukraine.

Introduction

The number of elderly citizens grows dramatically across the world, in absolute numbers but also in relation to the working-age population that can potentially provide care (Rothgang, 2010, p. 437). At the same time, women - the traditional providers of care within the family – have been entering the paid labour force in larger numbers than before and have thus much less time and drive to care. Due to the combination of these demographic and societal factors, the demand for long-term care (hereafter LTC) is intensifying across Europe. In many countries, including Germany, this demand is increasingly fulfilled by hiring migrant[1] care workers (Da Roit & Weicht, 2013; van Hooren, 2012).

In this contribution, we seek to explain the increasing reliance of the German LTC regime[2] on a migrant workforce. This outcome should be investigated given its implications for the future sustainability of LTC provision in Germany. The demand for migrant labour is likely to keep growing in the future due to population ageing and societal changes, but also because of some in-built features of the German LTC policy framework. Germany is already facing a severe shortage of care personnel (Böcker, Horn, & Schweppe, 2017, p. 228). By 2030, the deficit is projected to oscillate between 435.000 and 500.000 full-time equivalents (Rothgang, Müller, & Unger, 2012, p. 11).

From a theoretical point of view, Germany represents an interesting case study because it simultaneously encompasses elements from the 'migrant in the family' model of LTC provision said to characterize mainly Southern European countries (Bettio, Simonazzi, & Villa, 2006) and from the 'migrant in formal care' model characteristic of Nordic welfare states (Da Roit & Weicht, 2013).

The increasing reliance of the German LTC system on migrant workers manifests empirically as:

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[1] In this article, 'migrant' refers to individuals who (temporarily or permanently) migrated to another country than their country of origin *as adults*. We thus explicitly exclude the German statistical category of people 'with a migratory background' (*migrationshintergrund*).

[2] A 'care regime' is here defined as the financing, regulation, and provision of care in a country, given its social policy model, the interaction of its gender regime with labour market and training regulations and institutions, as well as the norms and ideals relating to these policy fields. Germany comes closest to the 'familialistic care regime' ideal-type, in which care for dependent relatives is considered a family obligation and public care provision is limited and subject to strong needs tests (van Hooren, 2012, p. 136).

- the spread of a 'migrant in the family' model of home-based elderly care (A)
- the parallel development of a 'migrant in formal care' model (B).

'Migrant in the family' care (A) refers to the provision of home-based care by migrants within private households, mostly on a live-in basis, with or without a legal employment contract. This type of care features migrant workers directly employed by households, but also agency-based employment. The 'migrant in formal care' model (B) refers to migrant workers with a regular employment status within non-profit and for-profit organisations providing outpatient or residential care.

In order to understand the increasing migrantization of the LTC workforce in Germany (hereafter 'the outcome'), we set to identify the interplay of causes that resulted in this development. As it has been demonstrated that current political and societal dynamics are profoundly shaped by the legacy of earlier policy choices (Streeck & Thelen, 2005), we started by reconstructing a chronology of events that lead to the outcome. The argument supported in this contribution is that the outcome is an unintended, medium-term consequence of certain features of the German long-term care insurance scheme (hereafter LTCI) introduced in 1995. We then transformed the chronology into two causal chains using the methodology of theory-guided process tracing, a variant of process tracing that enables "to know in advance where to look for causal mechanisms" (Trampusch & Palier, 2016, p. 442).

The article starts with a description of the explained outcome, followed by a short literature review of the factors contributing to the emergence of the 'migrant in the family' and 'migrant in formal care' models of elderly care provision. The third section is a short introduction to the methodology of causal process tracing that we used in this contribution. Section four reconstructs a chronology of events, which is then translated into two causal chains in section five.

I. The 'migrantization' of the LTC workforce in Germany

In this article, we are interested in 'migrants' in the sense of individuals who migrated (temporarily or permanently) to another country *as adults*. However, it is

difficult to obtain numbers on people who migrated to Germany as adults as most official statistics in the country refer to 'persons with a migratory background' (*migrationshintergrund*), a statistical category that includes foreigners who migrated to Germany as adults or children, but also first- and second-generation German nationals who were born in Germany from at least one foreign parent or from a parent who was born in Germany as a foreigner[3].

Depending of the estimation, the proportion of care workers 'with a migration background' is estimated at 10.2-11% in domiciliary care and 14-23% in residential settings (Theobald, 2017, p. 216). According to the German Federal Statistical Office, out of a total of 3.1 million people employed in the health and care sector in Germany in 2013, 419.000 health and care workers had a migrant background (183.000 of which originated from another EU country). Based on estimates, we can however conclude that formal care is probably a 'migrantized' occupation in Germany – the share of migrant workers in formal care (18 per cent) is higher than their share in the overall labour force (7 per cent) (Theobald & Hampel, 2013, p. 22).

The formal care sector in Germany draws from a migrant workforce with permanent work and residence rights, which means that migrant care workers are mostly nationals originating from CEE EU Member States (in particular Poland, but also increasingly Romania), as well as Kazakhstan, Russia and Ukraine (countries of origin of 'ethnic Germans'[4] who have the possibility to obtain German citizenship, (Theobald, 2017, p. 222)). Besides spontaneous labour migration, German authorities have also concluded specific recruitment agreements with several non-EU countries[5].

[3] The Federal Statistical Office of Germany defines persons with a migratory background (PMB) "as (1) persons who have immigrated to the Federal Republic of Germany (FRG) since 1949; (2) foreign citizens born in the FRG; and (3) all German citizens born in the FRG with at least one parent who either immigrated to the FRG after 1949 or was born in Germany as a foreign citizen." (Elrick & Schwartzman, 2015, p. 1543).

[4] Representatives of the German diaspora.

[5] For example, several hundred qualified nurses have been recruited in the framework of the "Triple Win" project inaugurated in 2013 and led by the Federal Employment Agency (*Zentralen Auslands- und Fachvermittlung*, ZAV) together with the German Society for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit*, GIZ). Involved countries included Bosnia-Herzegovina, the Philippines, Serbia and Tunisia. Similar agreements have been concluded with China, Mexico and Vietnam.

Every fifth person out of a total of 147.000 health and care sector workers originating from those CEE countries which joined the EU after 2004 (Rada, 2016, p. 4) stems from Poland (Statistisches Bundesamt, 2015). Poles are thus the largest group of workers with a migratory background employed in this sector, more numerous than all other migrant groups, including Turkish citizens (Rada, 2016, p. 4).

Additionally, since the 1990s, migrant workers have also been increasingly providing home-based care to severely dependent elderly within higher- and middle-income German households, often on a live-in basis (Becker, 2016; Kniejska, 2015, 2016; Lutz & Palenga-Möllenbeck, 2010; Satola & Schywalski, 2016; Shire, 2015; Shire, Schnell, & Noack, 2017). Research refers to this type of care provision as the 'migrant in the family' model, because employing households perceive migrants' services as a replacement for family-provided care (Kniejska, 2016, pp. 84-85). This type of care is mostly provided on a live-in basis: migrants live with the care receiver and are available to them almost 24/7. Research on 'migrant in the family care' in Germany has shown that even when workers do not live within the care receiver's household, "they are always nearby and able to help quickly if difficulties emerge" (Kniejska, 2018, p. 489). Although some live-in migrant carers have experience or training in nursing or care, the large majority does not have ad hoc formal qualifications (Böcker et al., 2017, p. 230) (despite many having tertiary education in other fields).

Employment in this type of care is mostly irregular, although possibilities for regular 'migrant in the family' employment exist since 2002 (Finotelli, 2008)[6]. Workers for this type of arrangement are found mostly through private networks or commercial placement agencies, which recruit mainly in CEE. Estimates of the number of such agencies in Germany vary between 50 (Krawietz, 2014) and 274 (Leiber, Rossow, & Matuszczyk, 2018, p. 11). They target almost exclusively households in Western Germany, probably due to higher average income in this part of the country (Krawietz, 2014)

[6] A specific 2004 recruitment programme run by the ZAV aimed at recruiting 'home helpers' from CEE. Recruited workers were to be employed in private households with LTC needs. Due to cumbersome administrative procedures, the take up was very low.

Concerning the numbers of migrant live-in care workers employed within private households, estimates range between 60.000 (Rostgaard et al., 2011, p. 154) and 300.000-400.000 (Satola & Schywalski, 2016). According to Hielscher et al., one out of every twelve households with a registered care recipient makes use of a live-in migrant care worker (Hielscher, Kirchen-Peters, & Nock, 2017, p. 10). Estimating the actual numbers of live-in migrant care workers is difficult because of the mostly irregular character of this type of employment. Additionally, a single household often employs two or more migrants who work on a rotational basis (Kniejska, 2018, p. 479). It seems however that live-in care by migrants has become one of the pillars of elderly care provision in Germany (Satola, 2014, p. 254). Lutz and Pallenga-Möllenbeck even concluded that the German care regime would collapse without live-in carers from abroad (Lutz & Palenga-Möllenbeck, 2011, p. 349).

In a comparative perspective, Germany ranks in-between countries such as Italy or Spain, where four to six people out of every 100 aged 65 or over are cared for at home by a migrant worker, and France, the Netherlands, Norway, Sweden or the UK, where the phenomenon has a very low incidence or is nearly absent (Da Roit & Weicht, 2013, pp. 473-474). Böcker et al. are much less moderate and conclude that "the employment of migrant care workers in private households has become a mass phenomenon [in Germany]" and the country's care regime "resembles in some respects those of Italy and other Mediterranean welfare states, where live-in migrant carers also appear to be quite common" (Böcker et al., 2017, p. 228).

II. State of the art

The literature on care and migration identifies structural causes, which – combined – are assumed to foster the migrantization of the care workforce. Each of these causes is in itself insufficient to produce the studied outcome, but combined, they contribute to it. These causes can be broadly classified into so-called 'push' (supply-side) and 'pull' (demand-side) factors.

Among the pull factors driving the migrantization of care provision in Germany, all sources mention increasing numbers of elderly people in need of care. It has already been demonstrated that migrant workers are generally overrepresented in low status jobs characterized by harsh or unpleasant working

conditions, and with limited chances of job mobility (Piore, 1979, pp. 17-19). Because care jobs are generally characterized by disadvantageous employment and working conditions (low wages, long working hours, night shifts, etc.), migrants are thus often concentrated in the sector to the detriment of other, more prestigious and better paid occupations (Da Roit & Weicht, 2013, p. 471).

Among possible causes of the emergence of 'migrant in the family' care, the literature has identified the limited provision of formal care services in the country under investigation (Bettio et al., 2006, p. 278; Lutz & Palenga-Möllenbeck, 2010), the availability of cash-for-care schemes that users can spend freely (Ungerson, 2004), the segregation of migrant workers in low-paid jobs (Da Roit & Weicht, 2013, p. 479) and a strong preference for family care (Böcker et al., 2017, p. 228). According to Da Roit and Weicht, it is the combination of these causes that stimulated the development of a 'migrant in the family' model in Germany (Da Roit & Weicht, 2013, p. 479). As a driver of 'migrant in the family' care specific to Germany, the literature cites the fact that the LTCI covers only a part of actual elderly care costs (Böcker et al., 2017, p. 228).

In Germany, women over 50 are generally preferred for 'migrant in the family' employment over younger counterparts (Karakayali, 2010, pp. 291-293; Kniejska, 2016). More generally, the demand for migrant care workers in Western European households is mostly aimed at white, Catholic and female candidates, to the detriment of migrants with other gender, ethnic and religious backgrounds (Safuta, 2018). These preferences combine with unfavourable socio-economic conditions in the countries of origin to specifically encourage the inflow of 'peripherally white'[7] migrants from CEE.

The migrantization of formal care is said to correlate with the presence of a large for-profit care sector in the country under study: the bigger the for-profit care sector in a national context, the more likely it is that the formal care workforce will be migrantized. Additionally, larger for-profit provision is "expected to increase opportunities for migrant care workers to enter formal care and to crowd out

[7] 'Peripheral whiteness' is a subject position of simultaneous privilege and subordination experienced by white migrants originating from non-Western countries (here CEE). For more on 'peripheral whiteness', see (Safuta, 2018).

(informal) employment in the domestic sector" (Da Roit & Weicht, 2013, p. 471). Countries with an overall bigger formal care sector also register a higher demand for migrant workers (Da Roit & Weicht, 2013, p. 471).

Among the push factors specific to formerly communist CEE countries, the literature mentions the mass unemployment that followed the post-1989 socio-economic transformation of that part of Europe. This unemployment affected more intensely the female-dominated sectors of the labour market, such as health and certain industrial branches (Robert, 2006, pp. 161-163). In short, the activation (or 'occupational empowerment') of women in Western Europe combined with the deactivation of their counterparts from CEE to stimulate flows of female migrants between CEE and the West, including Germany (Kniejska, 2018, p. 479). In accordance with the neoclassical theory of migration, (perceived) income differentials between CEE countries and their Western European neighbours also play a crucial role in encouraging migration (Cyrus & Vogel, 2006, p. 81).

With outflows exceeding one and a half million people, Poland has been one of Europe's biggest sending countries since the end of communism[8] and certainly since the 2004 enlargement of the European Union (Polakowski & Szelewa, 2016, p. 208)[9]. Since the 1980s, Germany has been a major destination for Polish labour migrants. General census data from 2011 show that this Western country has so far absorbed 470.000 Polish citizens (Polakowski & Szelewa, 2016, p. 210). In certain Western regions of Poland, such as Upper and Lower Silesia, migration to Germany has even become the main survival/earning strategy for inhabitants in age to migrate (Solga, 2002). As migrations from Poland to Germany have a long

[8] Post-war population movements between Poland and its neighbouring countries were followed by a long period of closed borders. Socialist regimes made regular migration virtually impossible and penalised attempts to migrate irregularly.

[9] Interestingly, Poland itself is a 'care crossroad', that is a country both sending and receiving migrant care workers (Safuta, Kordasiewicz, & Urbanska, 2016). Polish women migrate West, where they work in large numbers in formal and informal care settings and, at the same time, female migrants from Ukraine find employment in care in Poland (for more on this, see Safuta, 2017; Safuta et al., 2016).

tradition[10], broad migratory networks have arisen, which are among the pull factors facilitating migration.

III. Causal process tracing

Process tracing is a method of within-case analysis adapted to the study of causality (Falleti, 2016, p. 456). Process tracers seek to address some of the limitations of statistical analyses (Trampusch & Palier, 2016, p. 6). While statistical methods aim to show correlations and causal effects ("the expected value of the change in outcome when one or more independent variables change" (Falleti, 2016, p. 456)), process tracing identifies causal mechanism(s) linking one or more independent variable(s) to the outcome of the dependent variable (Beach & Pedersen, 2013, p. 1; George & Bennett, 2005, p. 206). To that end, process tracing establishes causal chains, which detail the process through which an outcome was brought about (Hedström & Ylikoski, 2010, p. 2).

In concrete terms, a causal chain breaks down the explanation of an outcome into a series of smaller successive steps linking initial conditions to the explained outcome. Successive steps are connected by causal mechanisms, that is, processes explaining the relation between two consecutive links. Preferably, each link should identify an entity that engaged in an activity, resulting in the next step (Beach & Pedersen, 2013, p. 39).

Many scholars define causal chains "as a series of empirical events that are temporally and spatially located between the occurrence of X and the outcome Y" (Beach & Pedersen, 2013, p. 33). For these authors, process tracing starts with the reconstruction of a chronology of events (Falleti, 2016; Falleti & Lynch, 2009) using narratives (Nullmeier, 2018). Because the order of events in chronologies is considered causally consequential (Falleti, 2016, p. 457), temporal narratives can subsequently be transformed into causal chains.

This contribution uses the 'explaining-outcome' variant of process tracing (Beach & Pedersen, 2013), which is the most often used common variety of the method. It aims "to craft a minimally sufficient explanation of a particular outcome,

[10] Estimates show that over 8 million people have migrated from Poland to Germany in the last 200 years. The literature identifies no less than 10 migratory waves between the two countries (Nowosielski, 2012, p. 4).

with sufficiency defined as an explanation that accounts for all of the important aspects of an outcome with no redundant parts being present" (Beach & Pedersen, 2013, p. 18).

In sociological research, causal chains should go beyond linking macro-level outcomes to each other and include interactions between the macro and micro levels**,** as well as interactions between individuals (Hedström & Swedberg, 1998; Hedström & Ylikoski, 2010)[11] : "Rather than analysing relationships between phenomena exclusively on the macro level, one should identify the *situational mechanisms* by which social structures constrain individuals' action and cultural environments shape their desires and beliefs, describe the *action-formation mechanisms* linking individuals' desires, beliefs, etc., to their actions, and specify the *transformational mechanisms* by which individuals, through their actions and interactions, generate various intended and unintended social outcomes" (Hedström & Ylikoski, 2010, p. 59).

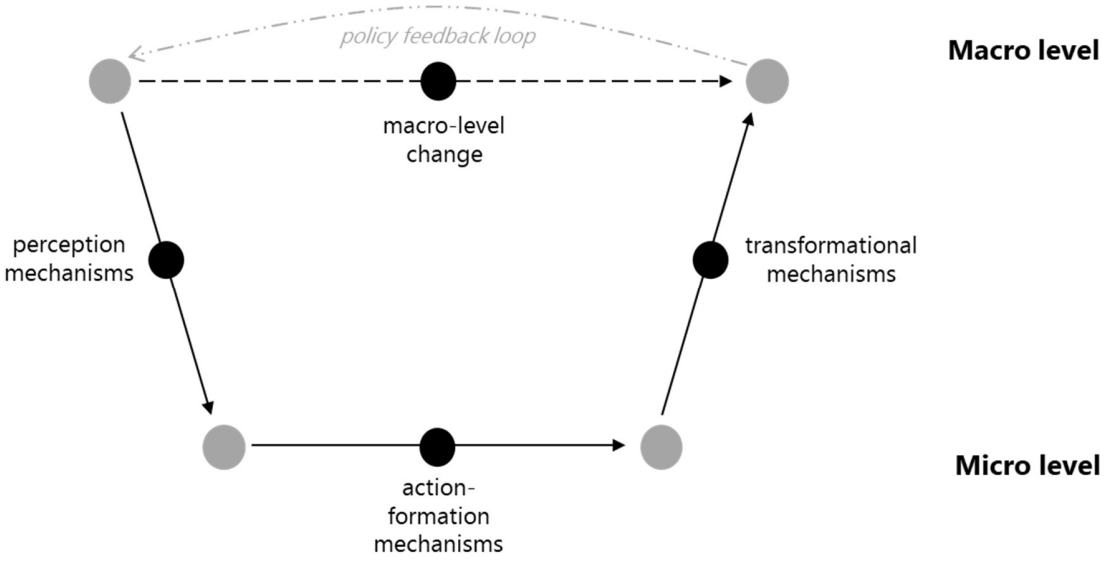
In order to account for transnational dynamics and the actions of macro-level actors such as political parties or expert elites, these three categories of causal mechanisms were subsequently transformed into mechanisms of *perception and translation* (when national actors learn about social policies in other countries and translate these into their domestic context), mechanisms of *cooperation and conflict* (when policies are negotiated at national level between different types of actors), and mechanisms of *collective decision-making* (when social policies are adopted or rejected) (Nullmeier, 2018).

In this contribution, we combine both frameworks in order to account for the aggregated actions of micro-level actors (individuals and households) and relate these actions to macro-level conditions. We speak of *situational mechanisms*, through which certain macro-level changes simultaneously constrain individuals' agency and offer them an opportunity structure for action, *action-formation mechanisms*, through which micro-level actors identify certain elements of macro-level conditions as opportunities for action in order to solve the problems they are

[11] Some authors do not agree with this claim and argue that the choice of level of analysis should rather be dictated by "the level at which the empirical manifestations of a given causal mechanism are best studied" (Beach & Pedersen, 2013, p. 43; Stinchcombe, 1991).

facing, and ***transformational mechanisms***, through which the aggregation of individuals' actions solving their individual problems creates empirically observable societal change.

Figure 1. Causal mechanisms in theory



IV. Chronology of LTC legislation in Germany

Mandatory long-term care insurance (LTCI) was introduced in Germany in 1995/1996. Two schemes have been established: a social and a private one, in line with the distinction between social and private insurance funds in the health care system (Rothgang, 2010). LTCI combined traditional features of Bismarckian social insurance with a market orientation in the form of competition between providers (explained below) and an emphasis on individual responsibility (Theobald & Hampel, 2013, p. 5).

Up until the 1990s, LTC was mainly a family task in Germany. It was only when families could not provide care themselves or afford its costs that municipalities 'took over' in the form of tax-based, means-tested social assistance for LTC purposes (Götze & Rothgang, 2014, p. 64). Municipalities' support was particularly needed in the case of residential care, as the costs of nursing home residency exceeded most old-age pensions (Götze & Rothgang, 2014, p. 70). The introduction of LTCI was thus primarily motivated by the growing financial burden represented by social assistance devoted to LTC[12].

When introducing the LTCI, policy makers did not however anticipate the effects of the combination of certain elements of the system they were establishing with the increased availability of a migrant workforce from CEE brought about by the end of communism and EU enlargements.

From the 1980s onwards, Germany became a major destination for labour migration from Poland. In the 1990s, Poles were at an advantage compared with other non-EU nationals, as they were exempted from the German visa obligation. After the 2004 enlargement of the EU to eight CEE countries[13], citizens of these new Member States did not have access to regular employment in Germany. Until May 2011, they could only work as self-employed service providers or as workers posted by a company based outside of Germany. Informally employed care workers were however at an advantage compared to informal workers from other sectors, as

[12] The number of individuals applying for social assistance to help them cover LTC expenses was increasing exponentially - from 165.000 in 1963 to nearly 660.000 in 1993 (Zuchandke, Reddemann, & Krummaker, 2012, p. 214). In 1991, LTC expenses made up more than one-third of the overall social assistance budget (Zuchandke et al., 2012, p. 215).

[13] The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.

workplace inspections rarely concerned households (Cyrus & Vogel, 2006, p. 76). Similarly, after their countries joined the EU in 2007, citizens from Bulgaria and Romania had to wait until January 2014 to access the German labour market without restrictions.

Should the incentives for labour migration from Poland decrease in the years to come, workers from other countries will take over the jobs currently held by Polish migrants, including in care. Such a shift is already ongoing, as the share of workers from Bulgaria, Romania and Ukraine increases in 'migrant in the family care' (Emunds, 2016, pp. 13, 190).

For a long time, there were no programmes actively recruiting care workers from abroad

(A) Skewed towards family care, the LTCI as adopted in the 1990s is (no longer) adapted to contemporary care needs. The LTCI aimed to limit public expenses and encourage citizens to take responsibility for their own LTC risks (Theobald & Hampel, 2013, p. 5). In line with those two objectives, LTCI provides only basic funding, that is, defined lump-sum benefits not covering the totality of a receiver's care needs (Theobald & Hampel, 2013, p. 9). The costs of formal care are thus only partially covered by capped LTCI payments. Families (and women within them) were to remain primary providers of LTC, LTCI was only to support them in that role (Götze & Rothgang, 2014). Hence, family care givers can apply for a pension contribution for years spent providing care (pension credit points'), they are insured against accidents occurring during caring activities and LTCI funds pay their unemployment, health care and LTCI contributions.

Crucially, the LTCI scheme not only created a right to services in kind, but also to unregulated cash benefits paid directly to beneficiaries. In practice, this means that citizens with a recognized need for care may opt for an unregulated cash payment, or choose benefits that can only be spent on home-based care services or used as a contribution towards the costs of institutional care. A combination of in-kind and cash benefits is also possible (Götze & Rothgang, 2014, p. 82).

The crucial argument behind the introduction of cash benefits was the idea that such payments would be an effective way to acknowledge, support and activate family-based care, which was to remain the main modality of LTC provision in Germany. Together with 'pension credit points', cash benefits were described as an incentive "particularly for women with low qualifications, to take over care responsibilities" (Theobald & Hampel, 2013, p. 15). For their part, civil society organizations (such as pensioners' and disability groups) advocated for cash benefits as a way to increase beneficiaries' autonomy in choosing their preferred mode of care provision (Theobald & Hampel, 2013, p. 10). The overarching argument behind direct cash payments was that they are a less costly way of supporting family care than the provision of benefits in kind (Theobald & Hampel, 2013, p. 10).

(B) The LTCI also aimed to increase the efficiency of formal care provision (Theobald & Hampel, 2013, p. 13). In line with the objective of a more effective (re)organisation of formal LTC provision, "the state adopted a regulatory role by defining the mode of interplay of different societal sectors, as well as types of care work and the qualification levels of carers" (Theobald & Hampel, 2013, p. 13). As part of this regulatory mission of the state, LTCI legislation introduced regulated competition between non-profit, for-profit and (the rare) public providers. Before the introduction of the LTCI, non-profit charity organizations had priority over for-profit providers. This meant that local governments had to contract charity organizations first and were allowed to contract for-profit providers or operate their own LTC services only if charities were unable to fulfil municipalities' demands (Götze & Rothgang, 2014, p. 70). In practice, this 'conditional priority' principle safeguarded the quasi-monopolistic power of non-profit organizations in residential care provision (Götze & Rothgang, 2014, p. 73). Regulated competition was perceived as a way of offering beneficiaries more choice between care providers (Theobald & Hampel, 2013, p. 17).

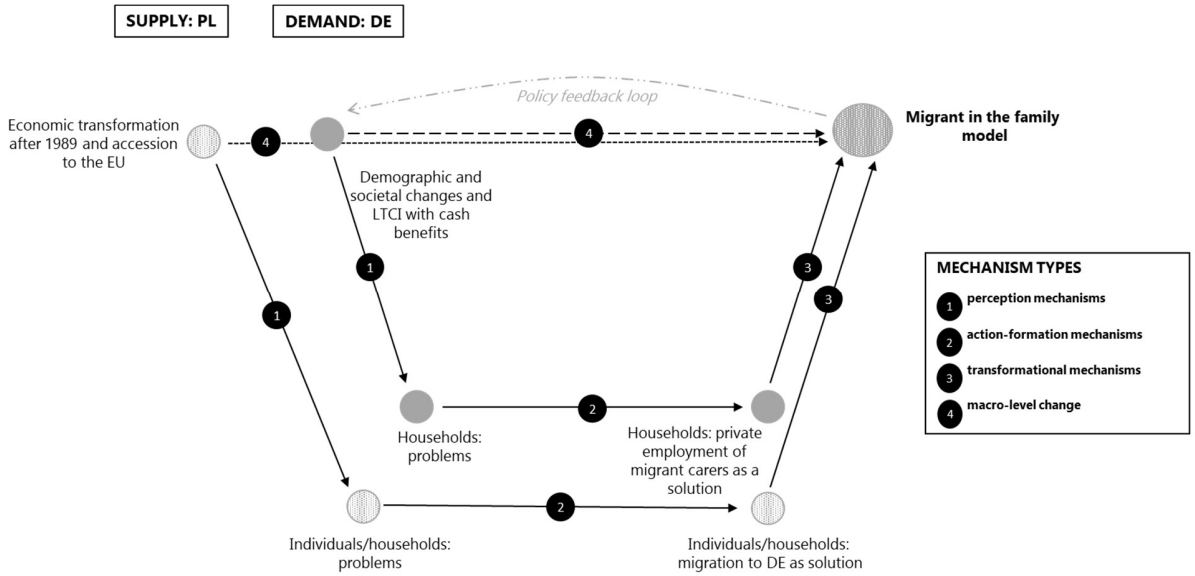
V. Two causal chains and policy feedbacks

Both causal chains presented here approach the studied outcome from the dual perspective of the demand for (in Germany) and supply of a migrant care workforce (originating from Central Eastern Europe, hereafter CEE). The aim is to explain the

increasing demand within the German LTC system for a migrant workforce (the demand side), given the availability of such a workforce from CEE ready to be employed in Germany (the supply side). On the demand side, LTCI legislation was characterised by two principles, which in turn kick-started two causal chains: (A) families (and women within them) were to remain primary providers of LTC, encouraged by cash benefits that can be spent freely, while (B) non-profit, for-profit and public care providers were to compete on an equal footing for beneficiaries.

On the supply side, the economic and political transformation that the CEE underwent after 1989 increased the number of individuals confronted with unemployment, bankruptcy, debt or low wages. Facing these challenges or simply encouraged by push factors such as wage differentials between the two countries or early retirement, individuals and households in this part of Europe seized the opportunity offered by the emerging East-West migration regime to undertake employment in Germany. In the 1990s, possibilities for employment in Germany were mostly limited to informal employment. In the framework of care employment, it meant that female migrants from CEE were mostly segregated into informal provision within private households. Opportunities for employment within formal care services emerged only with the opening of the German labour market to CEE citizens after 2011.

Figure A. The 'migrant in the family' mode of care provision in Germany



(A) The capacity/willingness of families to provide intra-familial LTC has been eroding since the 1960s (Götze & Rothgang, 2014, p. 70), due to a combination of factors. First, life expectancy has been increasing, while fertility rates have been stagnating (Statistisches Bundesamt, 2017). This development has been accompanied by an increase in single-person households (Krack-Roberg, Rübenach, Sommer, & Weinmann, 2016). This means that the pool of relatives able to provide care for elderly parents is decreasing, while overall numbers of people in need of care increase. Second, the labour market participation of married women (the traditional providers of family care) has been increasing (Götze & Rothgang, 2014, p. 71). Currently, women in Germany have much better employment perspectives than previous generations (Hobler, Pfahl, & Horvath, 2018) and are thus even less likely than before to provide unpaid informal care to relatives (Sopp & Wagner, 2013, 2016). Third, formal home-based care in Germany is geared towards providing only punctual relief to family carers, focusing mainly on medical and nursing tasks (e.g. administering medication or wound treatment) (Böcker et al., 2017, p. 237). It is thus ill-adapted to providing support with tasks which cannot be scheduled and in case of a need for nearly-constant supervision (in cases of dementia for example or when there is a high risk of falls). 'Migrant in the family

care' does not have such limitations and is often supplemented by formal home-based care (Böcker et al., 2017, p. 235).

Individuals and households in Germany are confronted on the one hand with care needs they are unable or unwilling to fulfil themselves, and on the other with LTC policies which do not offer many readily available and affordable alternatives to family care. The cash benefits offered by the German LTCI system are paid directly to the dependent person, who can then choose freely how to spend them (as long as proper care is guaranteed) (Rothgang, 2010, p. 439). This means that households make a 'make-or-buy' decision, deciding whether to keep the cash in the family or pay a care provider who is not a family member.

The inflows of migrants from CEE (especially Poland) to Germany that followed the post-1989 transformation (and intensified after Germany opened its labour market to citizens of those countries in 2011 and 2014, respectively) created the opportunity structure for German households to fulfil their care needs though privately hiring migrant live-in carers (perception mechanism A1). Encouraged by the unregulated character of the cash benefits offered by the LTCI, individuals and households started solving their LTC needs by informally hiring migrant domiciliary care workers (action-formation mechanism A2). As observed by Böcker et al., the employment of live-in migrant carers in private increased rapidly after 1995, after the introduction of unregulated cash benefits for home-based care within the LTCI framework (Böcker et al., 2017, p. 229). The aggregation of individual household decisions resulted in the emergence of a 'migrant in the family' model of LTC provision visible (transformational mechanism A3).

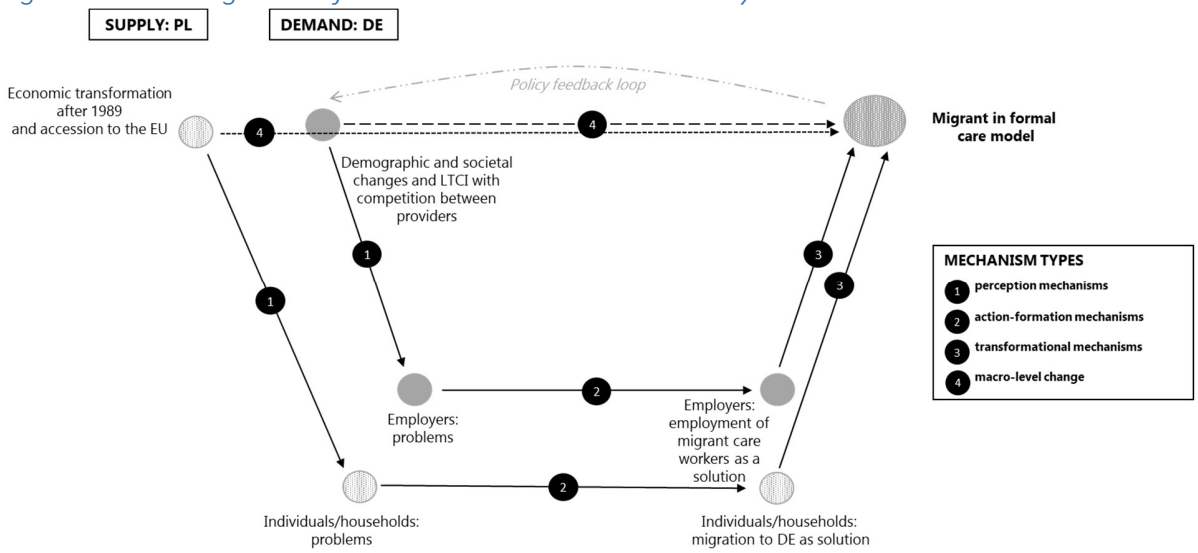
Largely unaltered since its beginning, LTCI underwent major reforms in 2008 (*Pflege-Weiterentwicklungsgesetz*), 2014 (*Erste Pflegestärkungsgesetz*), 2015 (*Zweite Pflegestärkungsgesetz*) and 2017 (*Dritte Pflegestärkungsgesetz*). Despite the spread of the 'migrant in the family' model of care provision, these reforms have not, so far, explicitly addressed the phenomenon. Germany did not follow the example of its smaller neighbour Austria, which introduced a legal framework regularising the grey market of home-based care provision by migrants (Österle & Bauer, 2012). Private brokering agencies placing Polish care workers in German

households are however aspiring to become authorised care providers within the LTCI framework (Leiber & Rossow, 2017, p. 11).

Instead, reforms rather focused on expanding the range of LTCI beneficiaries, introducing new types of benefits (some of which are targeted at informal care givers) and increasing the value of monthly benefits (Nadash, Doty, & von Schwanenflugel, 2018, p. 592). However, even after this increase, benefits are too low to cover the totality of the costs of formal outpatient or residential care. This contributes to the comparative attractiveness of informal live-in care provision, as LTCI benefits do not cover the total costs of formal care, but are generally sufficient to finance the salary of an irregularly employed migrant care worker (Kniejska, 2018, p. 479). Additionally, increasing care needs lead to less time per patient within formal care provision, which results in some households perceiving live-in migrant care not only as a cheaper alternative, but also as a potentially better-quality solution (Kniejska, 2018, p. 479).

LTCI funds can pay the statutory pension, healthcare, unemployment and LTCI contributions of individuals providing care to family members without remuneration. The 2017 reform of LTCI reduced the minimum of hours of care necessary to profit from this measure from 14 to 10 per week (Nadash et al., 2018, p. 591). It seems thus that the spread of the 'migrant in the family' model of care provision only triggered a reinforcement of the centrality of family care in the German LTC system (*policy feedback loop A*).

Figure B. The 'migrant in formal care' model in Germany



(B) Within formal care settings, the introduction of LTCI stimulated demand for care workers, due to the multiplication of care providers that followed the liberalization of the care market. The number of for-profit and non-profit organizations providing home care rose from 10,820 in 1999 to 12,745 in 2013, while at the same time the number of institutions providing residential care rose from 8,859 to 13,030 (Mätzke & Wiß, 2017, pp. 131-132). These providers have however been facing difficulties in finding native care personnel, due to a combination of poor working and employment conditions, and low wages. Several authors have concluded that the introduction of competition between care providers resulted in the deterioration of already unsatisfying employment and working conditions (Theobald, 2015; Theobald & Hampel, 2013, p. 35), as well as decreases in wages (Oschmiansky, 2013), which made the already unattractive care sector even less appealing.

Concerning employment conditions, non-standard employment has proliferated, as a way to better compete with other providers through lowering costs and increasing flexibility (Theobald & Hampel, 2013, p. 21). Between 1993 and 2015, the rate of part-time employment rose from 46.0% to 72.8% in home-based care, and from 35.3% to 68.8% in residential care (Theobald, 2017, p. 215). Many care workers are also employed with contracts at lower social security standards

(20.0% in home-based care and 9.2% in residential care, as of 2015 (Theobald, 2017, p. 215).

With regard to wages, home care providers are not always interested in increasing the prices of their services (and hence workers' wages), as they compete with each other on the one hand, and against informal care-givers on the other (Götze & Rothgang, 2014). Indeed, LTCI benefits are capped, which means they do not increase with inflation and can only be raised in the framework of a legislative procedure. Families with dependent elderly members have to pay the difference between the actual price of formal care and LTCI benefits in kind out of their own pocket. "With benefits capped, the private costs of using formal care services within the LTCI framework amount to 33% of total costs" (Theobald, 2017, p. 214). The private-to-public ratio of LTC expenditure in Germany is among the highest in the EU: in 2008, user charges amounted to 32.9% of overall LTC spending, while the remaining 67% stemmed from a combination of compulsory LTCI contributions (around 60%) and taxation (around 10%) (Lipszyc, Sail, & Xavier, 2012, p. 14).

In consequence, increases in the price of home care might encourage relatives to provide care informally and opt for cash payments instead of the benefits in kind (Götze & Rothgang, 2014, p. 84). It is thus not always in the best interest of providers to negotiate higher tariffs with LTCI funds, particularly for home-based care, which is the easiest to convert into family or 'migrant in the family' care.

The post-1989 transformation in CEE and the opening of the German labour market to citizens from these countries resulted in intense migratory inflows to Germany, in particular from Poland. Faced with increasing difficulties in finding native care personnel, employers in the German formal care sector discovered they can benefit from the migration kick-started by these macro-level events (perception mechanism B1). The mismatch between the increasing need for care workers and the difficulties in recruiting and retaining (native) candidates encourages employers to fill the gaps in the care labour force by hiring migrant applicants (action-formation mechanism B2). The aggregation of employers' individual hiring decisions within formal care provision leads to the migrantization of this sector (transformational mechanism B3).

Policy makers generally assume that increasing the attractiveness of care work will decrease the sector's dependence on a migrant labour force (van Hooren, 2012, p. 144). The 2018 reform of the training system of nurses and care professions (*Pflegeberufereformgesetz*) (*policy feedback loop B*) steers, at least in part, from a concern for improving the sector's attractiveness. When questioned about the reform's rationale, the federal Ministry of Health spoke of modernizing care training and increasing its attractiveness (Kleine Anfrage Drucksache 19/5654, 2018, p.1) (*policy feedback loop B*). This reform makes the training of care workers similar to the system that already exists in Germany for (male-dominated) industrial professions – while previous school-based training programmes for nurses required an unpaid internship, candidates will now be paid while in training[14].

Rather than reducing the reliance on a migrant workforce from abroad, this measure could however reinforce the sector's dualization – migrant workers predominantly cluster in unskilled care occupations (Rada, 2016, p. 8). Although most migrant care workers in the formal sector have formal nursing qualifications from their country of origin, those qualifications are often not recognised on par with German diplomas. Although specifically recruited by German care providers for their general nursing qualifications, Polish nurses trained in general medicine work in Germany as geriatric nurses (*Altpflegerinnen*) (Krawietz & Visel, 2016, p. 188) or care assistants (*Pflegehilfskräfte*), which impacts their salaries and career opportunities.

VI. Conclusions

This contribution aimed to explain the increasing reliance of the German LTC regime on a migrant workforce. The care sector in Germany seems to undergo a 'migrantization' process – the share of migrant workers in the sector increases and might even be higher than in the overall labour force. This migrantization manifests in two ways: on the one hand, there is a spread of home-based elderly care by migrant workers (A), on the other, the care workforce in formal settings increasingly consists of migrants (B).

[14] See https://www.make-it-in-germany.com/de/jobs/gefragte-berufe/pflegekraefte/.

We identified causal process tracing as the optimal method to explain both these outcomes. Process tracing establishes causal chains, which detail the process through which an outcome was brought about. We followed authors for whom process tracing starts from the reconstruction of a chronology of events using narratives, subsequently transformed into causal chains. Satisfactory causal chains in sociological research show macro-level change through referring to individual actions, as well as to interactions between the macro and micro levels.

The discussed outcome is produced by the interaction of several policy fields with a range of contextual factors. However, in this contribution we trace back the development of the 'migrant in the family' and of the 'migrant in formal care' models to concrete features of the LTCI as designed in 1995. In particular, the increasing migrantization of care provision within the German LTC system results precisely from a combination of two features of the LTCI (cash benefits and provider competition) with the readily available supply of a migrant workforce from CEE. The latter supply results from citizens of CEE countries, and Poland in particular, being forced to fight the micro-level consequences of unfavourable macro-level socio-economic conditions through the individual strategy of migration to the West.

As wage levels between the Western European and Poland will gradually equalise, the importance of Poland as a source country for the German LTC system should decrease proportionately, to the benefit of countries further East and South. It is however unlikely that the reliance of the German LTCI system on migrant workers will end any time soon, as care needs will only increase due to demographic changes. From the perspective of sending countries, the increased demand for migrant care workers in Germany contributes to emerging care gaps in the countries from which migrants originate. These gaps in turn stimulate the formation of transnational care chains, such as the one already linking Germany to Poland and Poland to Ukraine.

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