Working conditions of migrant and native workers in long-term care in Austria and Sweden: a tale of two countries and multiple backgrounds

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ABSTRACT

As demand for care has increased, the long-term care sector has been confronted with labour shortages that have been compounded by the low wages and often unattractive working conditions characterizing the sector. A number of European countries have more or less willingly attempted to address these labour shortages by employing care workers of migrant background. There has been a considerable body of research on migrant care workers employed directly be families, often in the context of grey markets of care. In comparison, there is a dearth of information on migrant workers employed in the care sector by formal care providers (e.g. care homes) and their working conditions. This gap is all the more relevant as there is reason to believe that this group of workers may be particularly vulnerable to abuse and poor working conditions.

This study aims to address that gap by comparing the working conditions and outcomes (stress, intention to leave, physical discomfort) of migrant care workers with native care workers in two European countries: Austria and Sweden. These countries share a high percentage of care workers of migrant origin (about ¼ of total workers), but are otherwise dissimilar as to the country of origin of these care workers and the organization of the care sector.

To this end we use data from a comparable survey on working conditions (the NORDCARE study) carried out in both countries (Sweden in 2015, Austria in 2017). This representative survey covered both the home care and the residential care sectors. We used logistical regression analysis to compare different outcomes and working conditions of native and migrant care workers.

Preliminary results show that in a number of variables capturing different dimensions of working conditions there are few differences between native and migrant carers in Austria, while in Sweden these differences actually disfavour natives. The findings for Austria are somewhat nuanced once nurses are included in the regression analysis, with migrant care workers showing worst results in more dimensions of working conditions. We discuss some of the possible reasons for these differences, including individual, organizational and institutional characteristics of individuals, providers and migration patterns in both countries.

INTRODUCTION

Demographic ageing and societal changes have led to an increase in the number of frail older people in need of long-term care, at the same time that the share of people of working age has declined across most European countries (Rodrigues et al 2012). This has enhanced the pressure on the formal care sector to meet the demand for long-term care. The ageing of the population has also meant that the formal care sector has faced labour shortages and difficulties in recruiting and retaining staff (OECD 2019). These difficulties are enhanced by the perceived low social status attributed to care work in general and long-term care in particular, which is reflected on the wage levels and working conditions prevalent in the latter (OECD 2019). Work in long-term care for older people remains deeply gendered, both in the characteristics of the workforce and of the care work itself, which is seen as ‘feminine’ and a ‘labour of love’ (England 2005).

The intersection of increased demand for labour and the unattractive working conditions of long-term care have often resulted in an increasing share of workers of migrant origin being employed in this sector (Cangiano, 2014). Some studies estimate that 20% of care workers in the UK and Sweden and about 30% of those in Austria are foreign born (Cangiano 2014, Christensen et al 207). Research on workers of migrant origin in the long-term care sector has highlighted the existence of a gap in terms of pay and working conditions in relation to native workers, as well as the existence of discrimination and racism (Cangiano 2009, Doyle and Timonen 2009, Jonson & Giertz 2013, Hussein et al 2014). However, the body of research on migrant working-condition differentials from a cross-country comparative perspective is very thin, particularly when using quantitative research methods (cf. Christensen et al 2017). The issue is all the more salient when care workers of migrant background may be considered a hidden population, even when working in the formalized sector, and may have less bargaining power to improve their working conditions. At the same time, in the absence of data that includes both workers of migrant and native background there is the risk of stereotyping and typifying the former and to take as discriminatory working conditions that are actually prevalent across the sector (Jonson & Giertz 2013). This is particularly the case when using single-country studies that may insufficiently consider the context in which migration and employment in the care sector intersect (Christensen et al 2017). This article aims to address this gap in knowledge by comparing the working conditions of workers of the long-term care sector with migrant and native backgrounds across two countries. Austria and Sweden face similar challenges in terms of demographic ageing and both have a sizeable share of their population receiving care services, either in their communities or in residential care. Despite these commonalities, they differ in terms of some of the regulations governing long-term care, namely those pertaining to the training of the long-term care workforce and migration policy histories and countries of origin. This should allow for a granular comparison between the two countries that accounts for these variations. This comparison is enabled by the use of a comparable dataset for both countries based on the NORDCARE study, which contains information on a wide array of dimensions of working conditions.

This paper is organized as follows. The next section details the background of migration and how the long-term care sector is organized in Austria and Sweden. This is followed by a description and argumentation of the data and methods used in the analysis. The findings are presented in section four and a discussion closes this paper. This paper focuses on long-term care for older people and for the remainder of the paper the term ‘care’ is understood as care for older people.

MIGRATION AND LONG-TERM CARE IN SWEDEN AND AUSTRIA

The provision of home care services for older people in Austria is overwhelmingly dominated by non profit providers, often faith or party-based. These large providers account for roughly 90% of all users of home care services in Austria (Rodrigues & Nies 2013), while for-profit providers are nearly inexistent. In residential care, public providers own the majority of the beds (61%), with the rest distributed between non-profit (27%) and for-profit (12%) providers. Home care services and residential care are funded by a mix of public subsidies (hourly rates for home care and daily rates for residential care) contracted directly between the regional authorities and each provider and out-of-pocket payments indexed to the users’ income. Users receive a universal cash benefit allowance (Pflegegeld) based on seven levels of assessed care need. The benefit can be used freely to pay for services (at home or in institutions) or to compensate for informal care as a ‘routed wage’. Up until the beginning of 2018 an asset contribution was also required when users moved into residential care. In theory, the cash benefit gives users the freedom to to choose the provider they want. However, as out-of-pocket payments are fixed by the regional governments, there is in practice limited price competition in either the home or residential care markets.

Staff employed in the care sector is subject to strict regulations stipulating their qualifications, which are set by the regional governments. Since 2005 there has been a concerted effort to harmonize these training requirements. These range from qualified nurses (Diplomierte Gesundheits- und Krankenpflege) who undertake a 3 year bachelor course and provide nursing care, to home helpers (Heimhilfe), who provide household care and support with activities of daily living and must undertake a 400 hour training course (equally divided between theory and practice). In between there are the professional social carers (Fachsozialbetreuung Altenhilfe), providing social care and nursing care under supervision, who qualify after undertaking a 2 year course (equivalent to 2400 hours of training); and the nursing assistants (Pflegehilfe), who provide nursing care under supervision and whose training consists of 1600 hours. Any of these staff categories may be employed in the home or residential care sectors, but the organization of care tasks in each sector make some job profiles more prevalent in one setting than the other. As a result of these regulations, there is a tendency for professionalization at both the higher and lower end of occupations in care in Austria. In addition to these regulations, collective labour agreements play also an important role in regulating working conditions and pay in the care sector in Austria. Although there is no minimum wage in Austria, all employees regardless of nationality are covered by collective agreements that determine the remunerations of different occupations. These collective agreements however, differ greatly not only within regions but sometimes within providers (Der Standard 2015).

Apart from qualifications, staff ratios for residential care are also regulated at the regional level in Austria. These stipulate no only the ratios, but also the composition of staff for any given level of care need. For example, in Vienna, at least 30% of care staff in residential care has to be comprised of nurses. Given the devolved responsibility for staff ratios, there are wide variations on the requirements across regions, with at least one region (Salzburg) not stipulating any staff ratios at all (Gratzer & Staflinger 2016).

The number of people residing in Austria who had foreign citizenship amounted to 1.341,9 million in 2017, approximately 15.3% of the resident population (Statistics Austria & Austrian Academy of Sciences 2017). In the same year those born outside of Austria (with and without an Austrian citizenship) accounted for 18.9% of the resident population. By far the largest group of residents with foreign citizenship are Germans, representing 13.5% of those with foreign citizenship (Statistics Austria and Austrian Academy of Sciences 2017). They are followed by Serbian (8.8%), Turkish (8.7%), Bosnians (7.0%), Romanians (6.9%) and Croatians (5.5%). Migration into Austria followed several waves. The 1960s and 1970s were characterized by the denominated ‘guest worker’ (Gastarbeiter) regime characterized mostly by male immigration from former Yugoslavia of temporary nature to offset labour shortages in Austria (Fassmann & Reeger 2008). Migration flows diminished in the 1970s due to the economic downturn with new entrants mostly consisting of female migrants from former Yugoslavia ad Turkey arriving under family reunification schemes. There was a large increase in migration in the early 1990s, motivated mostly by the conflict in the former republics of Yugoslavia, which brought many refugees into Austria. Many of these earlier foreign nationals settled in Austria and ended up acquiring Austrian citizenship. The accession of Austria to the European Union (EU) in 1995 brought about a new influx of foreign nationals, mostly from EU countries.

Migrants paid directly by private households as live-in carers to frail older people residing in their homes have become a feature of long-term care in Austria (Österle & Bauer 2012). These carers, known as ‘24-hour carers’, usually operate in tandems, each providing round-the-clock care for a fortnight before returning to their country of origin. They are perceived as a cheaper alternative to home care services, with an estimated 60.000 of these 24-hour carers providing care mostly as self-employed personal carers (Wirtschaftskammer Österreich 2017). The phenomenon of migration linked to these 24-hour carers has been extensively studied (Österle & Bauer 2012, 2016). On the contrary, there is very little information about the size and working conditions of the migrant workforce employed in care services in Austria, although some evidence suggests that some 24-hour carers go on to find a job in the care service sector (Österle & Bauer 2016).

Sweden, like the other Nordic countries, has a long history of universal provision of tax-funded, publicly provided care services financed and managed by the municipalities. However, starting in the 1990s a number of legislative changes (namely, the 1991 Local Government Act and the 1992 Act on Public Procurement) has aimed to increase the diversity of care providers. This was mainly achieved by encouraging municipalities to outsource publicly financed care services (both residential and home-based) to private for-profit and non-profit providers, based on competitive tendering, and by the introduction of customer-choice models, in particular for home-care services. As a result, since the beginning of the 1990s, the share of for-profit provision has grown from virtually zero to around 18% while the non-profit has remained stable around 3% (Erlandsson et al 2013; Szebehely & Meagher 2018). In contrast to Austria, the size of the for-profit sector is similar in home care and residential care, and in both sectors, around eight in ten care workers are publicly employed. It should be noted however that the implementation of these reforms was quite uneven as municipalities ultimately decide whether and to what extent to implement the reforms.

Both residential and home care in Sweden are regulated by the Social Services Act. The legislation is a goal-oriented framework law ensuring a general right to assistance if needs cannot be met in any other way, but without specific rights or regulation of service quality. The responsibility to provide services and to follow up on service quality rests with the local authorities who have a high degree of autonomy vis-à-vis the central government. In comparison to Austria, there is much less regulation of qualifications in the care workforce. The Social Services Act only stipulates that services should be of good quality and that there has to be staff with adequate training. In addition, users in residential care facilities must have access to registered nurses and there has to be staff at night in all care homes.

Registered nurses make up for 7% of the entire care workforce (disability and long-term care combined). Their education requirements are similar to Austria (3 years bachelor degree), but in Sweden registered nurses are tasked with mainly supervising care workers and rarely carry out hands-on care. The majority of the long-term care workforce are assistant nurses (undersköterska), followed by care aides (vårdbiträden) (SOU 2019:20). One of the policy goals in Sweden is to gradually replace all care aides with assistant nurses, and as such the latter group has grown at the expense of the former. In 1995 there were three times more care aides than assistant nurses; in 2015 the assistant nurses were twice as many as the care aides. However, difficulties to recruit and retain skilled care workers have led to an increase of care aides in the last few years (SOU 2019:20, p. 73).

Formally, assistant nurses are required to have three years of upper secondary education (2500 hours) but there are entry points into this profession so this is a highly heterogeneous group of long-term care workers in terms of education and skills. A care aide may have no or just a short formal training (800 hours). Despite these training requirements, neither assistant nurses nor care aides are regulated occupations however. Worries about an uneven level of skills and the lack of regulation have been criticised and a government commission has recently suggested that assistant nurse should become a regulated (licenced) occupation with a national standard.

Even if training levels have increased over time as a result of various state initiatives, still one in five residential care workers and one in four home care workers lack relevant training for the work (Stranz & Szebehely 2017), and the training level is lower in the for-profit than in the public sector (Theobald et al 2018). Irrespective of title and level of formal training, assistant nurses and care aides are doing more or less the same tasks in home care as well as in residential care: a combination of household chores, personal care and – on delegation by a registered nurse – handing out medication and giving insulin injections. The division of labour between these two groups of long-term care workers is very limited, but assistant nurses do more of the administrative tasks and they also more often give injections than care aides (Daly & Szebehely 2012; Stranz 2013).

There are no national staffing ratios in Swedish residential care, but in international comparison the staffing level is relatively high (Harrington et al., 2012). According to statistics from the National Board of Health and Welfare (Socialstyrelsen 2018), on average, there are three care workers (assistant nurses or care aides) and 0.4 registered nurses per ten residents in a nursing home.

The share of the population born outside country is very similar in Austria and Sweden. In 2018, 18% of Sweden’s ten million inhabitants were foreign born, an increase from 9% in 1990. Like Austria, migration to Sweden has followed several waves, from labour force migration in the 60s and 70s (mainly from Finland, Greece and former Yugoslavia to refugees from countries outside Europe and family reunions in more recent years (Aldén & Hammarstedt 2014). Today half the foreign-born population were born in Asia, Africa and Latin America (Statistics Sweden 2019a).

In contrast to Austria, there are no migrant (or native) care workers employed as live in carers or 24-hour carers in private households. Further, there is hardly any labour force migration specifically into the care sector. However, also the Swedish long-term care services rely increasingly on care workers born in other countries, and there are several government and local initiatives to train and recruit recently arrived migrants to work in long-term care services (Storm 2018). In 2017, in residential care, 28 per cent of the care workers were born outside Sweden in 2015, an increase from 17 per cent in 2008. In the metropolitan area, more than half the workforce were foreign born (Socialstyrelsen 2019:48). Two thirds of the foreign-born care workers are born in Asia, Africa or Latin America (Statistics Sweden 2019b).

DATA AND METHODS

This study is based on a large comparative survey carried out in Sweden and Austria, which contains extensive information on the work organization, working conditions, health and safety, conciliation of work and family life and individual characteristics of workers in the long-term care sector in each country (Trydegård 2012). The questionnaire used was identical and distributed by e-mail to a random sample of workers taken from the union records from Sweden, and by mail and through an online link sent to workers of a random sample of providers in three regions in Austria (Vienna, Upper Austria and Salzburg) stratified by region and ownership type of providers. The survey was carried out between March and May 2017 in Austria and a total of 1110 workers out of 3926 responded to the survey, corresponding to a response rate of 28.3% (Rodrigues et al 2018). In Sweden the fieldwork was carried out between September and December 2015 during which a total of 2000 workers were contacted via post, of which 532 turned out not to work in long-term care and 30 had moved and were not possible to reach. Of the remainder 1438, 770 answered the postal survey resulting in a response rate of 53.5%. In both surveys, migrant/native workers were defined as those born outside of/in Austria and Sweden respectively.

Registered nurses were not included in the Swedish sampling for this study since in the context of the Swedish long-term care sector they mostly perform supervision tasks. To increase the comparability between the samples of the two countries, the observations from nurses in Austria were excluded from the analysis. This resulted in the loss of 295 observations in the Austrian sample. A separate analysis for the whole Austrian sample (i.e. including nurses), was nonetheless replicated as a sensitivity analysis and results are reported in the annex. The sample including registered nurses had 1098 valid observations.

One possible limitation of the study design is comparability between the two samples, given that the Swedish sample only includes unionized workers. While unionization rates in Sweden stand at 70%, in Austria this figure is much lower (28%) (European Trade Union Confederation, 2019). Restricting the sample to unionized workers would thus risk leaving a significant non-random number of workers out of the Austrian study, particularly those with poor working conditions, rendering it not comparable with the Swedish sample that in effect covers most of the workers in the sector. For the purpose of this study, which focuses on migrant workers, sampling unionized workers only could raise the issue of whether migrant workers and those with poor working conditions are properly represented. The very high unionization rates observed in Sweden seem however to be common to both the public and private sectors and comparable between native workers and those with a migrant background. The unionization rates for public and private firms is 87% and 74% respectively for workers born in Sweden and 85% and 75% for those born outside of Sweden (Kjellberg 2010, quoted in Jonson & Giertz 2013: 812). As an additional caveat it cannot be ruled out that response rates might have differed among migrant workers with limited command of German or Swedish (the languages of the questionnaires in each country), who might also be those with poorer working conditions.

The dependent variables consist of a series of dichotomized variables related to different dimensions of working conditions. The variables mostly capture self-reported experiences, with the exception of type of employment contract, which is an objective condition. The original variables included in the survey included more than two values assessed along an ordinal Likert scale. For the dichotomization, the two extreme negative answers were considered. This decision followed mostly a theoretical underpinning, but sensitivity analysis showed that results were not sensitive to the cut-off point used. The dimensions and dependent variables used are depicted in Table 1.

[Insert Table 1 here]

The differences in working conditions between migrant and native workers are analysed first through bivariate logistic regression, to assess overall differences, and then using multivariate logistical regression to account for the possible heterogeneity of migrant and native workers in each country. The multivariate logistical regression controls for differences in the individual characteristics of individuals, however, it is unlikely that observations can be considered independent from their counterparts within each country, given the influence that context and institutional factors particular to each national long-term care setting may have. To account for this and given the impossibility of using multilevel statistical analysis as there are only two clusters (i.e. countries) we have decided to run an independent analysis for each country, thus allowing for all coefficients to vary between the two subsamples (Scott & Siltanen 2017).

RESULTS

Descriptive statistics describing migrant and native care workers in each country are presented in Table 2. The share of migrants is quite similar in both samples: about one in four workers who responded were born outside each of the countries were the survey was conducted. In both countries, migrant care workers have a higher share of men than their native counterparts although in any case women make up for the overwhelming majority of the long-term care workforce sampled in each country. Education as currently coded is not strictly comparable between the two countries. However, in both cases migrant carers seem to concentrate in particular qualifications following a distribution that is somewhat different from native care workers. In the case of Austria, migrant carers seem to cluster around home helpers and nursing assistants, while for Sweden they cluster in the group of workers with 1-2 years of formal training. In Sweden in particular, migrant workers tend to have somewhat shorter training. . For the Austrian sample, the experience in the long-term care sector, measured through an ordinal variable, is remarkably similar between migrant and native care workers, as is their median age. In Sweden, natives have longer experience despite having a similar median age than migrant care workers.

In both countries, part-time work is a feature of work in the long-term care sector. In Sweden, both migrant and native care workers have very similar working schedules. In Austria, on the contrary, migrant care workers have longer working schedules than native care workers, with almost half of the former working full-time. As their native counterparts, the overwhelming majority of migrant care workers in Austria is satisfied with their working arrangements, although around 12% would like to work less. For Sweden, the overwhelming majority of native and migrant care workers are also satisfied with their working time, but a sizeable minority of migrants would like to work more (22%). Finally, the distribution of migrant and native care workers by care setting is very similar in both countries, although migrant care workers are slightly over-represented in the home care sector in Austria and in the residential care sector in Sweden.

[Insert Table 2 here]

The bivariate analysis shows that in both countries migrant and native care workers do not seem to report different working conditions for the majority of dimensions and variables considered (Table 3). Among the exceptions to this general rule is peer support, for which migrant care workers in Austria report lower odds than their native co-workers of having lower scores for this variable. In both countries, migrant care workers have much higher odds of receiving comments of xenophobic nature than native care workers. At the same time however, migrant care workers in Austria seem less likely than native workers to report lack of control (low ability to influence their work plan), physical abuse or sexual harassment. They are also less likely to report feeling stress or having too much work to do. In this case, they are unlike migrant care workers in Sweden, who have higher odds of feeling stress than their native colleagues. Migrant care workers in Sweden are also relatively disadvantaged in relation to their native co-workers when it comes to the nature of their working contract, as the former have higher odds of having a non-permanent contract. In Austria this finding is not apparent, not least of all because permanent contracts are the rule in the sector: 95% of all workers sampled reported having a permanent contract. In Sweden, care workers of migrant background had lower odds of reporting low scores in the ability to learn new things at work, of feeling than insufficient care was provided to users and of reporting physical abuse. They were also less likely than native care workers to want to leave the long-term care sector.

[Insert Table 3 here]

Multivariate analysis allowed for the heterogeneity of migrant and native care workers in each country to be controlled for. When controls are added, very few differences remained between migrant care workers and their native colleagues in Austria. The former remained more likely to report being the target of xenophobic comments in the workplace and receiving less peer support. They also report having lower odds of experiencing lack of control over their work plan. For Sweden, the multivariate analysis shows statistically significant differences between migrant and native care workers for reporting low scores in the possibility to learn new things, having too much do to (stress), being the target of xenophobic comments, physical abuse and sexual harassment or feeling physically tired after work. Among all these variables however, migrants are only relatively disadvantaged (i.e. have higher odds than native care workers) in the variables related to stress and being the target of xenophobic remarks.

As mentioned in the Data and Methods section, registered nurses were not included in the above analysis for either country. As information on them is available for Austria – as they perform hands-on care in both care settings, unlike in Sweden – the bivariate and multivariate analysis was replicated in a larger sample that included nurses for Austria (Appendix A table). The inclusion of nurses changed the findings, as migrant care workers show poorer working conditions vis-à-vis native care workers in a number of variables (bivariate analysis). These variables include low scores for learning something new or finding the work interesting, difficulties in conciliating work and family life, low support from co-workers, being the target of xenophobic remarks or feeling mentally exhausted. The previous finding that migrant care workers had lower odds than natives of reporting low influence in their work plan and experiencing physical abuse in the workplace were confirmed when including nurses in the sample. Most of these results held after controlling for confounders (multivariate analysis). Only the odds ratios for low scores in finding the work interesting and difficulties in conciliating work and family life lost their statistical significance.

DISCUSSION

Using a rich dataset in terms of different variables assessing working conditions and individual characteristics of workers has enabled the study of potential discrimination facing migrant workers of the long-term care sector in Austria and Sweden. The findings suggest that differentials in working conditions between migrant and native workers are limited in each of the countries considered. Migrant care workers in both countries were however, much more likely to be the target of xenophobic remarks, an experience that seems pervasive across countries (Cangiano 2009). In Austria, this was despite the fact that the majority of migrant workers were nonetheless European in origin. Many of the migrant care workers in Sweden were born outside of Europe, which could mean that they had more conspicuous social markers (e.g. skin colour) that elicited xenophobic remarks from users, co-workers or supervisors (Hussein et al 2014). Language barriers could have accounted for the lower peer-support that migrant care workers reported in Austria in comparison with their native colleagues. In Sweden this result was not apparent, which may account for the different organizational features or care work, or the longer number of years that migrant care workers in Sweden had spent on average in the long-term care sector.

Migrant care workers in Sweden were more likely to feel stressed than natives, even after controlling for working time. In Austria this result was not apparent even though migrant care workers there also worked longer hours than their native colleagues. Despite feeling more stressed than their native colleagues, migrant care workers in Sweden were less likely to feel physically exhausted than them. They were less likely to experience physical abuse or sexual harassment then native care workers. While the latter could also mean a lower awareness of what constitutes sexual harassment among migrants, both results are nonetheless noteworthy given the relative low status and vulnerability that migrants usually experience.

Migrant care workers in Sweden had a relatively positive view on the possibility to learn new things on their jobs, which could be explained by the fact that many migrants work as care aids, which may not necessarily entail a formal qualification and for which many entry points exist. In this case, learning on the job may contribute to keep it novel and interesting. Furthermore, in Sweden, asylum seeking is one of the main entry channels of migrants working in the care sector (unlike in Austria), which could also increase the attractiveness of learning a new profession on the job (Cangiano 2014). In Austria, no such differential was encountered, except for when nurses were included in the sample. Qualification requirements in Austria are relatively high in terms of number of training hours required for the majority of occupations in long-term care. For foreign-born nurses there might be issues around the recognition of their qualifications, they might have worked in the acute care sector at home and perceive tasks in the long-term care sector as less challenging, or they might have experienced de-skilling. Regarding the latter possibility however, there seems to be little mismatch between qualifications and occupations in the Austrian sample (Bauer et al 2018). In the Austrian sample, migrant care workers were less likely to report low scores in the ability to influence their work plan. This finding held even after including nurses in the analysis. With the inclusion of nurses, migrant care workers in Austria were more likely to report feeling mentally exhausted than their native colleagues. Overall the differences observed when including nurses highlight the potentially diverging working experiences among migrants with different qualifications within a country and definitely warrant further analysis.

This study has a number of caveats that should be considered when interpreting the results. The response rate of the Austrian sample was relatively low, which could raise the possibility of biases in sampling. The lack of official statistics comprising more data than just age and gender profile for the long-term care workforce in Austria limits the assessment of potential biases beyond age and gender. However, the response rate at an organizational level, i.e. those providers that accepted to distribute the study among their workforce, was quite high in Austria across different ownership types, which offers some additional reassurances in this respect (Bauer et al 2018). The type of analysis carried out allowed us to account fully for broader different contextual settings in Austria and Sweden, by running separate logistical regressions for each national sample. This approach however, diminishes the sample size on which regressions are run and thus increases the size of standard errors in the estimation and the possibility of type-II errors (real differences are not statistically significant). Finally, the findings reported here are preliminary results of still ongoing analysis.

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Table 1: Dependent variables for working conditions

|  |  |
| --- | --- |
| Dimensions | Variables |
| Demands | Limited possibility to learn something new on the jobLow scores on finding work interesting |
| Time | Experiencing stress/too much work to doDifficulties in conciliating work and family lifeFeeling that insufficient care was provided to users due to lack of time |
| Control | Low scores on influence or capacity to affect planning of work |
| Support | Low scores in feeling support from colleaguesLow scores in feeling support from supervisors |
| Outcomes | Having a non-permanent employment contractReceiving sexist commentsReceiving xenophobic commentsExperiencing sexual harassmentExperience physical violenceFeeling physically exhausted after a working dayExperiencing pain in the back after a working dayFeeling mentally exhausted after a working dayExperiencing sleeping difficulties because of thoughts of work Wanted to leave the sector |

Table 2: Characteristics of native and migrant care workers in Austria and Sweden (percentages refer to within migrant and native groups in each country)

|  |  |  |
| --- | --- | --- |
|  | Austria | Sweden |
|  | Native | Migrant | Native | Migrant |
| Gender |  |  |  |  |
| Male | 95 (12.4) | 51 (16.1) | 34 (6.4) | 18 (10.1) |
| Female | 672 (87.6) | 269 (83.9) | 494 (93.6) | 160 (89.9) |
| Education |  |  |  |  |
| Level 1 | 93 (16.0) | 40 (19.0) | 43 (8.3) | 17 (9.7) |
| Level 2 | 136 (23.3) | 80 (37.9) | 47 (9.1) | 17 (9.7) |
| Level 3 | 201 (34.4) | 15 (7.0) | 198 (38.2) | 95 (54.3) |
| Level 4 | 153 (26.3) | 76 (36.2) | 231 (44.5) | 46 (26.3) |
| Age (median) | 44.9 | 45.6 | 46.3 | 47.8 |
| Years in the care sector |  |  |  |  |
| 0-5 years | 159 (27.3) | 60 (29.0) | 86 (16.4) | 39 (21.7) |
| 6-9 years | 139 (23.8) | 56 (26.8) | 53 (10.1) | 35 (19.4) |
| 10-19 years | 185 (31.8) | 62 (29.7) | 150 (28.6) | 79 (43.9) |
| >=20 years | 100 (17.1) | 30 (14.4) | 235 (44.8) | 27 (15.0) |
| Working-time |  |  |  |  |
| Full-time (>35h per week) | 199 (35.2) | 106 (51.4) | 231 (47.1) | 82 (50.0) |
| Part-time (>25h per week) | 225 (39.6) | 84 (40.6) | 210 (42.9) | 64 (39.0) |
| Part-time (<=25h per week) | 143 (25.2) | 17 (8.1) | 49 (10.0) | 18 (11.0) |
| Satisfaction with hours worked |  |  |  |  |
| Satisfied | 519 (90.4) | 172 (81.5) | 432 (82.1) | 125 (70.2) |
| Wanted to work more | 26 (4.5) | 13 (6.3) | 68 (12.9) | 40 (22.5) |
| Wanted to work less | 30 (5.2) | 26 (12.2) | 26 (4.9) | 13 (7.3) |
| Care sector |  |  |  |  |
| Home care | 204 (26.4) | 103 (32.1) | 173 (32.7) | 50 (27.9) |
| Residential care | 571 (73.6) | 219 (67.9) | 356 (67.3) | 129 (72.1) |
| Total | 585 (72.9) | 217 (27.1) | 529 (74.7) | 179 (25.3) |

Note: results weighted.

Table 3: Odds-ratios for migrants experiencing worst working conditions than native care workers

|  |  |  |
| --- | --- | --- |
|  | Austria without nurses | Sweden |
|  | Bivariate | Multivariate | Bivariate | Multivariate |
| Low scores in learning new things | 1.346 | 1.116 | **0.610\*\*** | **0.501\*\*** |
| Low scores in work being interesting | 1.658 | 1.107 | 1.185 | 1.359 |
| Stress/too much work to do | **0.696\*** | 0.713 | **2.092\*\*\*** | **2.059\*\*\*** |
| Difficulty conciliating work/family | 1.385 | 1.167 | 0.772 | 0.706 |
| Insufficient care provided to users | 0.699 | 0.683 | **0.653\*\*** | 0.757 |
| Low influence work plan | **0.512\*\*** | **0.542\*\*** | 0.753 | 0.786 |
| Low peer support | **1.928\*\*** | **1.504\*** | 1.098 | 1.244 |
| Low supervision support | 1.211 | 1.218 | 0.900 | 0.888 |
| Non-permanent contract | 1.257 | 1.398 | **1.579\*** | 1.491 |
| Xenophobic comments | **1.993\*** | **2.196\*\*** | **1.984\*\*** | **2.544\*\*** |
| Sexual harassment | **0.289\*\*** | 0.365 | 0.457 | **0.295\*** |
| Physical violence | **0.490\*\*** | 0.561 | **0.469\*\*** | **0.359\*\*** |
| Physically exhausted | 0.758 | 0.937 | 0.729 | **0.572\*\*** |
| Pain in the back after work | 0.970 | 1.189 | 1.196 | 1.065 |
| Mentally exhausted | 0.971 | 1.093 | 0.925 | 0.892 |
| Sleeping difficulties because of work | 0.936 | 0.868 | 1.315 | 1.020 |
| Wanted to leave the sector | 1.336 | 1.233 | **0.720\*** | 0.834 |

Note: \* p-value <0.1, \*\* p-value <0.01, \*\*\* p-value <0.001.

Multivariate analysis controls for age, gender, years in the care sector, education, care sector and working time. Weighted results.

Appendix A: Odds-ratios for migrants experiencing worst working conditions than native care workers for Austria, including nurses

|  |  |
| --- | --- |
|  | Austria with nurses |
|  | Bivariate | Multivariate |
| Low scores in learning new things | **1.547\*\*** | **1.489\*** |
| Low scores in work being interesting | **3.561\*\*** | 2.674 |
| Stress/too much work to do | 0.832 | 0.783 |
| Difficulty conciliating work/family | **1.724\*\*** | 1.198 |
| Insufficient care provided to users | 0.766 | 0.679 |
| Low influence work plan | **0.616\*\*** | **0.666\*\*** |
| Low peer support | **2.316\*\*\*** | **1.905\*\*** |
| Low supervision support | 1.167 | 1.197 |
| Non-permanent contract | 0.763 | 0.885 |
| Xenophobic comments | **2.132\*\*** | **1.867\*** |
| Sexual harassment | 0.567 | 0.557 |
| Physical violence | **0.604\*** | **0.568\*\*** |
| Physically exhausted | 1.021 | 1.129 |
| Pain in the back after work | 1.126 | 1.252 |
| Mentally exhausted | **1.496\*\*** | **1.437\*** |
| Sleeping difficulties because of work | 1.278 | 1.060 |
| Wanted to leave the sector | 1.309 | 1.201 |

Note: \* p-value <0.1, \*\* p-value <0.01, \*\*\* p-value <0.001.

Multivariate analysis controls for age, gender, years in the care sector, education, care sector and working time. Weighted results.