Chapter 7

Labour Mobility from Eastern European Welfare States: Zooming in on Romania and Slovakia

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7.1 Introduction

Throughout Europe, care is provided mostly within families, with public welfare provisions supporting and complementing these family efforts (Bettio and Plantenga 2004). Notions such as ‘care deficit’¹ (Hochschild 1995) or ‘crisis of care’ (Triandafyllidou 2013) describe care deficiencies within both families and public welfare systems. In the last two decades, care deficits in Western Europe have been fuelled by demographic and social transformations, such as population ageing, changes in household structures (where nuclear families no longer live with their extended families), welfare programme reforms and an altogether lower involvement of the state in care provision (Leon 2014). These care deficits, particularly in high-income countries, have been addressed through, for instance, migrant labour which, in turn, contributes to increasing care needs in the migrants’ sending countries.

Previous studies on care mobility and care migration² have analysed transnational care practices and transnational families, as well as the ways in which migrants informally re-organise family care obligations in their home countries

¹A ‘care deficit’ is seen as the result of an increased need for care and difficulties in contracting a matching supply (Hochschild 1995).

²Following the UN definition of migration, which is a change in a person’s place of residence for at least three months (UN 1998), the term ‘mobility’ implies fewer than three months of stay abroad.

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(Alpes and Van Walsum 2014; Bauer and Österle 2016; Escriva and Skinner 2008). Research on family migration found that caring responsibilities within migrants' families are constantly negotiated (Evereti and Ryan 2011). This is, to a certain extent, described as the 'mobility of care' (Baldassar 2007), which implies that responsibilities develop over time and are also influenced by cultural expectations about caring obligations within families. Previous studies also showed that the ways in which migrants' families re-organise their care commitments in the sending countries are linked and, to a certain extent, depend on the care regimes there (Bahna and Sekulová 2019; Bettio and Plantenga 2004). However, less attention has been given to specific contexts of welfare provision in countries of origin, particularly with regard to the linkages between family care needs, cultural attitudes towards care and care workers' mobility (Rogoz and Sekulová 2019).

This chapter explores the re-organisation of care within families – caused by care workers' mobility – in the sending countries. It argues that what can be called a 'familialistic' orientation of relevant welfare policies in sending countries has an influence on labour mobility patterns. Through the case study of Romanian and Slovak live-in caregivers³ working in 2- or 4-week shifts in Austria, the chapter analyses the linkages between care workers' strategies for addressing the care deficits of their families living back home, the deficiencies of related public policies in their respective countries of origin and the care workers' mobility patterns. It argues that, when it comes to the relationship between mobility and care needs, there seems to be a 'tipping point' in the needs of care workers' families which makes care workers decide to permanently return to their countries of origin in order to care for their family members. As care deficits in migrants' families emerge mainly in relation to children and elderly family members, we focus here specifically on childcare and care for the elderly. The remainder of this chapter unfolds as follows. First, contextual information is provided on care-work mobility, as well as on current public policies in the areas of childcare and elderly care in Romania and Slovakia. Second, the chapter's conceptual framework is laid out and the methodology employed briefly described. Third, the main body of the chapter addresses family care re-organisation due to care mobility, the effects of the family's care deficits and of welfare provisions of care on mobility and care re-organisation in families with a mobile carer. Finally, the last section draws the main conclusions and summarises the contribution's central argument.

³Live-in (24-h) care provision by migrant care workers represents a specific type of mobility/migration in Central and Western Europe. For more information about the specifics of live-in care work in Austria and its developments, see Österle and Bauer (2012), Sekulová and Rogoz (2019) and Winkelmann et al. (2015).

7.2 Family-Related Policies in and Care Mobility from Romania and Slovakia

In many Western European countries, families' care needs are increasingly being complemented through migrant work – be they citizens of other EU countries or third-country nationals. The main differentiating aspect of care-work mobility from other types of labour mobility lies in its over-representation of female migrants. For the purpose of this paper, 'care work' refers to all types of assistance provided to support the daily life of a dependant in a family setting, either in the carer's own family or as a remunerated assistant in the household of an unrelated dependant. In this sense, care work can be either indispensable (for young children, for the severely ill) or needed in order to improve the quality of life (such as supporting someone with a disability, depending on the degree of disability). Care work or the labour aimed at supporting family and household reproduction referred to by feminist scholars as reproductive labour, can entail a large array of activities – from domestic work to providing company for an elderly person who lives alone. The cultural framework of care, particularly in Eastern European countries, attributes the main responsibilities to women and thus the labour mobility involved affects family care capacities in countries of origin.

Care mobility from Romania and Slovakia to Austria is mainly economically driven and is encouraged by wage differences and limited labour-market opportunities in the two countries compared to Austria (Bahna 2014). Most live-in caregivers work in Austria in private households, in 24-h personal care for the elderly. Caregivers from Romania and Slovakia commute regularly⁴ on a short-term basis between Austria and their respective countries of origin. According to our research, in general, Romanian care workers commute to Austria in 4-week shifts – usually working uninterrupted 4 weeks in Austria and then going back to Romania for 4 weeks. Slovak care workers commute on a 2-week schedule – that is, they work 2 weeks in Austria and then go back to Slovakia for 2 weeks. According to internal statistics from Caritas Austria,⁵ the Romanian care workers in Austria are younger than the Slovak carers. Most of those from Slovakia are middle-aged women and only a few have children under 15 (Bahna and Sekulová 2019). Consequently, the unmet care needs in the country of origin emerge differently in Romania compared to Slovakia. While, in Romania, women's care-work mobility affects both childcare and care for the elderly, in Slovakia it dominates the area of elderly care.

In both Romania and Slovakia, paid parental leave for early childcare is available for the first 3 years, depending on a child's needs (Búriková 2016; MMJS 2016). In Romania, nurseries are available for children between 3 months and 4 years old (Monitorul Oficial 2009). While nurseries for children younger than 3 years exist in

⁴The circular mode of care provision has been determining care mobility to Austria since its beginnings, in the early 1990s, before the 2007/2008 legalisation on migrant care work (Österle and Bauer 2016).

⁵Shared directly with the authors in the framework of their research.

Slovakia, the widely accepted social norm is that young children are best cared for at home (Saxonberg 2011). Eastern European countries score the lowest in Europe when it comes to the use of formal childcare services for those under 2 years old. Thus, the share of children aged 0–2 in formal childcare arrangements was less than 20% in Romania and under 10% in Slovakia in 2012 (Plantenga and Remery 2015). According to data from Eurostat (2018), Romania and Slovakia also have some of the lowest rates of paid formal childcare for children below 12 years of age. In 2017, just 3% of children in Slovakia and only 1% in Romania received any form of paid formal care before they turned 12.⁶ In addition, the states provide complex sets of financial support for children's education. In Slovakia, the core consists of child benefit (EUR 24.34 in 2019) paid monthly up to 18 years old or, if the child goes on to study at college or university, up until the completion of these studies or a maximum of 25 years old. At the same time, there is parental benefit (EUR 220.70 in 2019) paid monthly until the child reaches the age of three – or up to 6 years in particular circumstances (e.g. the poor health of the child, etc.).⁷ Similarly, in Romania, all children (under 18 or, if older, until graduation), are entitled to monthly paid benefits of around EUR 31 for children aged 2–17 and EUR 62 for all children with disabilities⁸.

Care for the elderly subscribes to provisions under the long-term care system, which comprises a complex range of health and social services for the elderly and/or persons with disabilities who are dependent on help with their daily activities over an extended period of time (Hirose and Czepulis-Rutkowska 2016). Most European countries do not define this as a separate social field (Spasova et al. 2018). In Romania, for instance, long-term care includes measures aimed at supporting the elderly and disabled (Council of the European Union 2014; Popa 2010), the responsibility for which is split between different levels of the administration – social-service provision falls under the responsibility of local authorities, with NGOs playing an important part, while the financing mechanism combines central and local resources. The social services available under long-term care are the following: homecare, care provided in day centres and care provided in residential centres (European Commission 2019). In Romania, there are no cash benefits for

⁶This Eurostat analysis is based on the EU-Statistics on Income and Living Conditions (EU-SILC) *ad hoc* module 2016 (Eurostat 2018). Paid formal childcare refers to childcare by a professional childminder at either the child's or the childminder's home: 'Parents are often employers and pay the carer directly; furthermore there are no controls over the qualification of the childminder by an organised structure. "Professional" childminder shall be understood as a person for whom looking after the child represents a job of work or paid activity. The term "professional" does not contain a notion of qualification or of quality of care. Babysitters and "au pairs" are also included here' (Eurostat 2017: 4).

⁷For details, visit the website of the Slovak Central Office of Labour, Social Affairs and Family: https://www.upsvr.gov.sk/socialne-veci-a-rodina-2/davky-pre-rodiny-s-detmi/prehľad-davok-pre-rodiny-s-detmi.html?page_id=696894. Accessed 14 September 2020.

⁸For details, visit the website of the Romanian Directorate-General for Social Assistance and Child Protection: <https://dgaipc3.ro/servicii-dgasp/ajutoare-sociale/copii-si-familii/alocatii-de-stat-pentru-copii/>. Accessed 14 September 2020.

the informal care of the elderly, only for those who are officially recognised as disabled. However, if the person has been assessed as disabled, he or she can benefit from a care allowance granted to a member of the family (European Commission 2016a). While both public and private residential homes exist, these are either insufficient or too expensive (particularly the private ones). In order to access public residential homes, contributions by the general public increased from 26% of the total cost in 2012 to 30% in 2016 while, to access private residential homes, a person has to pay more than 70% of the cost (Pop 2018). Thus, long-term care for the elderly in Romania is provided mainly on an informal basis.

In Slovakia, the long-term care system consists of formal care services provided by professionals either in residential institutions (nursing homes, hospitals etc.) or at home (Council of the European Union 2014; Radvanský and Lichner 2013; Repková 2011). Municipalities are in charge of social services, as they have the main responsibility for the provision of community social-care to the elderly. Regional- and county-level administrations are responsible for residential services for the elderly and persons with disabilities. Private services are somewhat rare due to the low purchasing power of people in need of social and health services (Repková 2012). Formal care provision, both institutional and in private homes, covers around 14% of those who need care in Slovakia (Radvanský and Dovál'ová 2013). The long-term care system in Slovakia has four main clusters of carers: those providing care informally within their families (and receiving cash benefits to provide this care to a family member registered with the authorities), home nursing personnel (who are employees of municipalities or private providers), personnel in residential care facilities and volunteers. Informal carers (nearly 60,000 persons), mainly family members of those in need of care, may apply for a cash benefit (European Commission 2016b), provided through the network of local labour, social affairs and family offices (European Commission 2016b). Entitlement to these cash benefits is means tested and the claimant's income and assets cannot exceed a certain ceiling. As the income increases, the cash benefit is reduced (European Commission 2016b). Recently, the basic cash benefit increased significantly, from EUR 249.35 in 2018 to EUR 430.35 in 2019.⁹ Officially recognised informal carers are, at the same time, insured (health and pension insurance) by the state and entitled to some public services which are marginally used (European Commission 2016b).

7.3 Concepts and Theoretical Perspectives

The extent to which informal care is provided by family members and the responsibilities which this entails differ significantly across Europe (Bettio and Plantenga 2004; Saraceno and Keck 2010). Informal care refers the most commonly to all

⁹For details, visit the website of the Slovak Ministry of Labour, Social Affairs and Family: <https://www.employment.gov.sk/sk/rodina-socialna-pomoc/tazke-zdravotne-postihnutie/penazne-prispevky/pp-opatrovanie/>. Accessed 14 September 2020.

unregulated, mostly unpaid activities to support children, elderly relatives or others, while formal care provisions can be defined as regulated by policies or other forms of contractual arrangements between individuals (Bettio and Plantenga 2004). In addition to the relationship between the carer and the person cared for, the setting is also important: care work provided within a household, by a family member to another family member – which is often but not necessarily unpaid – is also categorised as informal care. However, the concept of informal care is narrower than that of reproductive labour or unpaid work in a broad sense for it refers specifically to situations wherein the care is provided by a close family member, a relative or a close friend, often without a formal qualification for providing such care (cf. Repková 2012). In practice, the boundaries of situations described by these concepts are often blurred – some carers, as the example of Romanian and Slovak caregivers in Austria shows, may have vocational training in the field of care. In childcare, the concept of informal care refers to an array of activities carried out by members of the extended family in order to support children at home. The concept of formal care in this context, however, refers to formalised care services provided by professionals in residential care, day-care facilities, day centres or private households. Similarly, informal care for the elderly is provided by a family member, often within the same household, and often but not necessarily unpaid.

The literature on informal caregiving and the culture of care finds that its organisation differs between diverse national and cultural settings (Pharr et al. 2014). In addition, cultural norms and attitudes towards care influence the distinction between informal care provision and the utilisation of institutional frameworks. Although women remain the predominant caregivers, the extent and form of their involvement in family care depends upon cultural norms, family structures, social policies and welfare provision. Extended families where the members share resources allow greater flexibility in caring responsibilities. Typically, grandparents may provide care to grandchildren or adult daughters can share caring responsibilities for elderly parents. However, even nuclear families may still rely on extended family care resources while living separately – with one of the parents living abroad. A recent cross-country analysis of 35 long-term national care systems¹⁰ found that, although over the last 10 years (2008–2018), there have been some changes in the distribution of caregiving tasks in general, ‘women continue to take responsibility for and to carry out the bulk of caregiving’ across Europe (Spasova et al. 2018, 30). A Eurobarometer report on health and long-term care in the European Union found that women were ‘more often fully involved in informal care than men’ – 47 vs 36% in 2007 (European Commission 2007, 83). The same report finds that ‘women are slightly more likely than men to expect to have at least partly to give up paid work to care for their elderly parents in the future – 9 vs 6 per cent’ (2007, 90). When asked about the best care option for an elderly person who lives alone, 56% of Romanian and 47% of Slovak respondents consider that living with one of their

¹⁰The synthesis is based on 35 country reports by the European Social Policy Network (ESPN) country teams, covering: EU member states, North Macedonia, Iceland, Liechtenstein, Norway, Serbia, Switzerland and Turkey (Spasova et al. 2018).

children is the best (European Commission 2007). More-recent studies show that, in Slovakia, social norms expect families to stay together and women to be responsible for family care (Bosá et al. 2009; Voľanská 2016). Similarly, a study on long-term care found that, in Romania, most informal caregivers are women – as a rule wives or daughters (Popa 2010).

Existing studies underline the connections between the extent of informal care provision, general institutional frameworks and states' involvement in responsibilities in the area of care (Brandt et al. 2009; Verbakel 2018). From a state institutional perspective (Brandt et al. 2009), formal and informal care are complementary and an extensive welfare state – with wide support for care – may motivate family members to provide less-intensive informal care, where this latter is defined as care provided for a minimum of 11 h per week (Verbakel 2018). On the other hand, less state involvement may lead to family members providing more intensive informal care. According to Verbakel (2018), in countries with extensive long-term care provision, individuals are more likely to provide informal care, while the likelihood of intensive caregiving is lower. Countries with less state involvement have fewer informal caregivers but more intensive care is provided.

Care provision in terms of services provided to those in need of care and the general recognition of the role of the family depend on national contexts. The role of social policies and welfare provision with regard to care can be categorised on the familialism/de-familialisation continuum (Esping-Andersen 1990; Leitner 2003; Saraceno and Keck 2010). The differentiating indicator on this continuum is the presence of policies that explicitly support the family in its caring functions. At one extreme – familialism – family members are expected to remain responsible for caring for their relatives and the elderly in particular (Bettio and Plantenga 2004). According to Saraceno and Keck (2010), familialism refers to policies which, usually through financial transfers, taxation and paid leave, support family members in keeping up with their care responsibilities. De-familialisation means the opposite, the when individualisation of social rights reduces family responsibilities and dependencies (Saraceno and Keck 2010) and, instead, makes the state responsible for welfare provision. The position on the familialism/de-familialisation continuum of welfare provision with regard to care, as the example of Romanian and Slovak caregivers shows, influences care workers' mobility patterns. Both Romania and Slovakia display a 'familialistic' (Österle 2010) long-term care system. Data from the 2016 European Quality of Life Survey (EQLS)¹¹ confirm that both Romania and Slovakia are among the countries with the lowest proportion of people using formal long-term care services themselves or having someone close who had used the service – with 3 and 2% of respondents, respectively (Eurofound 2017a). Although the number of public care homes increased considerably in recent years in both Romania

¹¹ The fourth EQLS was carried out from September 2016 to March 2017 in all EU member states and the five candidate countries (Albania, the former Yugoslav Republic of Macedonia, Montenegro, Serbia and Turkey). It was coordinated by Kantar Public, with local partners interviewing a total of nearly 37,000 people in 33 different countries, with sample sizes ranging from 1000 to 2000 per country (Eurofound 2017a: 9).

(by 30% from 2008 to 2014) and Slovakia (by 39% between 2004 and 2017) (Eurofound 2017b), the limited availability of residential services in the two countries contributes to the importance of care provided by family members.

7.4 Methods and Data

This paper draws on qualitative data from 60 in-depth, semi-structured interviews conducted in Romania and Slovakia between October 2017 and March 2018.¹² The selection of care workers was based on several criteria, among which the residing region in sending countries, working in care for the elderly abroad and having caring responsibilities for their own family dependants in their respective countries of origin (either children or the elderly) were the most relevant. Of these, 18 were semi-structured interviews with care workers and their adult family members, with a focus on the care needs of families and the use of care services delivered by private or public service-providers in the two countries of origin. This paper also draws on five additional, qualitative, semi-structured interviews with care workers in Slovakia and Austria – three Slovak and two Romanian – conducted outside the REMINDER project. These five additional interviews focused on the role of informal care in caregivers' families, the ways in which the provision of care was re-organised within the family and the cultural norms concerning women's role in this re-organisation.

7.5 The Needs of Care Workers' Families and Strategies Employed to Address Them

The rich body of literature on transnational care practices and transnational families has addressed the ways in which women re-organise family care obligations while working abroad (Alpes and Van Walsum 2014; Bauer and Österle 2016; Escriva and Skinner 2008). Many Romanian and Slovak caregivers who work in Austria have family care obligations at home – towards their own children and grandchildren, their own parents or other older relatives. Despite working abroad, they remain, to a certain extent, responsible for family care and continue to be involved in the decision-making processes in their families (Bauer and Österle 2016; Sekulová 2013, 2015).

¹² The data were collected mainly in the framework of a Horizon 2020 project REMINDER ('Role of European Mobility and Its Impacts in Narratives, Debates and EU Reforms'). The REMINDER project was part of a larger study exploring under-researched aspects of the social and economic implications of intra-EU mobility on the sending countries in the Eastern part of Europe. For more details visit <https://www.reminder-project.eu/publications/work-packages/wp6-countries-of-origin/>. Accessed 14 September 2020.

Like earlier findings (Bauer and Österle 2016; Sekulová 2013, 2015), where care workers have care obligations towards their own family members, we found that the re-organisation of care follows family ties whereby the husband/partner and grandmothers play the most important role(s) during the absence of the main caregiver. Family care is thus most commonly delegated, depending upon family type (nuclear, two-generational, kin-network nearby), to spouses, grandmothers or older children. Importantly, the delegation of care to other family members is only temporary, until the caregiver returns home (Sekulová 2013).

Caregivers referred to the need for financial resources as one of the main current problems for their families. The financial aspect is closely related to family care, as remittances are being spent on the different care-related needs of family members. For instance, Katarína, a caregiver from Slovakia, mother of three children, spends remittances from Austria on school-related expenditure such as study fees or student accommodation for her children. Some care workers, such as Helena (50) from Slovakia, may also provide support to adult family members with financial constraints:

Now, when I leave for Austria, my son does not cook, so he eats at restaurants. The money I earn for care work I spend on basic family expenditure.

In the specific case of Romanian and Slovak care workers commuting to Austria, family care needs and the strategies employed to address them are determined by the short duration of caregivers' stays abroad, which typically range from 2 to 4 weeks in Austria and followed by an equal amount of time spent in their home countries. This mobility pattern enables care workers to take charge of a significant volume of family care responsibilities, as 47-year-old Katarína, from Slovakia, explains:

[Because I return after two weeks] I take over the responsibility in the household for everything. But I must admit that my children make an effort to at least prepare the house before I come. They tidy up, wash the dishes, my daughter even irons. But it is automatic, that once I return home, everything lies on my shoulders. They help, but not intensively, and only if I am absent.

We found that, while the ways vary in which families cope with the mobility of the main caregivers, the family care needs of Romanian and Slovak caregivers working in Austria have a substantial influence on the care-work mobility project. Changes in a family's care needs over time, as the health situation of family members changes or the children grow up, determine the scope of the care worker's mobility. Family needs determine the caregivers' return home to take over emerging caring responsibilities, as the following chapter illustrates.

7.6 Care Needs as a Determinant of Mobility: The Tipping Point

Recruiting migrant caregivers from other countries as a strategy to cope with deficits resulting from one's own care migration – and known as care-chain migration – is not evident in the Slovak context (Bauer and Österle 2016; Búriková 2016; Sekulová 2013). Instead, we found that extensive family care obligations represent a constraint on mobility, as women with particular care obligations are less likely to migrate.

Our material suggests that Romanian and Slovak women only work abroad if their respective families do not suffer from a care deficit. If care workers themselves declare that a big part in their decision to return is played by the care needs of members of their families, then the absence of these care workers from their families begins (at least from a certain point onwards) to create a care deficit in the family. While care workers are abroad, families cope with their care needs as long as these needs are quite limited. In other words, there seems to be a tipping point in the care needs of care workers' families, which determines that care workers can no longer work abroad but must to return to their countries of origin to fulfil these duties. Thus, the women in our sample often started to work as caregivers abroad after their commitments to family dependants ended (after the parents or parents-in-law passed away, for instance). Similarly, their decision to permanently return home and no longer work abroad was often taken due to their family's new care needs.

Two Slovak carers whom we interviewed had been providing informal long-term care for their parents until they passed away and only afterwards did they start working as carers in Austria. In spite of the financial constraints due to loss of a wage during the time they provided informal care to their own family members, both considered it as unacceptable to work abroad and leave their parents without care or in state-provided residential care facilities. Diana took care of her mother for 5 years until the latter passed away. For Diana (49 years old) this was considered part of her duties as a daughter, even if this meant a difficult life period for herself. She did not consider resorting to residential care services – at that time largely regarded to be of poor quality and insufficient – even though her mother would have been eligible for them.

After my mother passed away, I started [to work as a caregiver in Austria]. I was happy that I took care of her until she passed away [rather than placing her in residential care]. But it is a very sad and difficult story which I went through. The state did not help me in anything at all. Nothing, nothing, nothing.¹³

Maria, a 49-year-old woman from Slovakia, decided to return back to her home country to look after her mother, whose health had worsened:

[For] two weeks I would live with my mother, helping her and spending time with her. When I went abroad, my sister would spend two weeks with her and look after her. In

¹³ The care worker interviewed made reference here to both support in kind and cash support.

September 2018, she got seriously sick and her health worsened. [...] We discussed what to do and whether she would become dependent upon [the] care of other people. All this happened in December 2018. So, I decided to quit my job. At the beginning, I took unpaid leave from my work¹⁴ and searched for opportunities to be employed as a full-time carer of my mother... However, my mother passed away in mid-January 2019. Therefore, in February, after a few weeks at home, I returned and since then I have been working as a caregiver in Austria normally [on the two-week rotational scheme].

Andrea, a 35-year-old care worker originally from the Republic of Moldova, is married in Romania, where she lives with her husband and their three children. While she works in Austria on a 4-week shift, her children are cared for either by her mother, her husband or her brother, depending on who is available at the time. Her husband works in Italy and comes home every 3 months. Her brother, who previously worked in Germany, was searching for a job at the time of the interview. One of the stories shared by Andrea shows that, although care is being organised and transferred to other family members, she remains heavily involved in care at home, particularly when extraordinary situations arise:

Violence is really an issue in their school. When I returned home last time, my son was injured [...] and he even needed specialised medical care... Because that took place while I was in Austria. And my mother did not know to go there [to enquire about the situation at school] ... but [upon return,] when I saw that bruise on his hand, I went to the police and the police sent me to get a medical certificate [that he was hit]. And after two weeks [since the incident] he still needed to spend four days in hospital. ... Sometimes we leave our children but even in schools they are not safe. ... [The school] did not react in any way. The boy who hit him got a lower mark but nothing else happened. ... My son no longer wants to go to that school and I decided with my husband to get him into another school.

Irina, 36, has been a care worker in Austria since 2013. Previously, she had been working in Romania but when her company started to have problems paying employees' salaries, she resigned and begun looking for intermediaries who could help her to find a job as a care worker abroad. She had no previous experience as a care worker in Romania. At the time of the interview, her two children – aged eight and nine – were living with her husband and parents-in-law while she worked abroad. In the event that her parents or parents-in-law need her to care for them, she has said that she will no longer work in Austria. However, as long as this is possible, she wants to keep the job. Her grandmother passed away last year but, in the final period of her life, the family employed a woman from the same village to take care of her. Irina is currently working 4-week shifts. She is considering moving to Austria with her husband and the two children.

Oana, A 25-year-old Romanian care worker, single mother of a 4-year-old, has been working for nearly 2 years in Austria. She had previously worked in the Czech Republic as a supply manager in a warehouse and in agriculture. After returning to Romania, she heard about care work from her acquaintances. She likes being a care worker. Her son is currently living with her mother, grandmother and brother. When

¹⁴As self-employed caregivers in Austria are not entitled to paid leave (as in regular employment), the reference here is to the fact that the family in Austria (the recipient of care services) used the services of another caregiver at that time.

Oana is in Austria and there is financial need in the family, her brother steps in. She plans to find employment in Romania to be closer to her family. When her mother and grandmother get older, she plans to leave her job in Austria and take care of them herself.

One must find a way to do both [take care of home and work abroad]. But I like the work I am doing and I try to do everything at home as well. ... The needs are many – I am a single mother, I raise my son by myself. And it is difficult. But things are better now. He is four and a half. ... My son stays with my mother and my grandmother. Sometimes my brother is involved as well. Practically, my mother has been involved since my son was two weeks old, so that I can work to support the family. ... My mother has diabetes and cannot work. Her medicine costs about 100 EUR per month and my grandmother has a very small, minimal pension. So, I must work... When I leave, it is very difficult. When I return home is the most beautiful thing but it is very difficult. To be a mother [and leave your child] is difficult.

In addition, caregivers may work abroad due to the care systems in their respective country of origin. In the Slovak sample, for instance, one woman was able commute to Austria due to the existing state-provided care services. Lena, 55 years old, divorced and mother of four children, one of whom had severe disabilities, said she needed a break and a change after she had been caring for her daughter for 17 years. Because of financial constraints and the need for a life change, she placed her daughter in a residential care home and left to work in Austria. Whenever she comes back to Slovakia for 2 weeks, she takes her daughter home.

I was officially registered as a carer, by the Labour Office, of my own child. I did not have responsibility for more clients, only for this one particular person. My daughter. So the state paid me, the scheme had a title 'care for a relative' at that time... The income, however, was very low and it was impossible to pay the rent for a three-room apartment, expenditure on my children's education and other costs. Without a second part-time job, 4 hours per day, I would not be able to survive, to cover all the necessary expenditure. And, to be precise, we overcame these problems thanks to my parents' financial contribution... So, I decided to try something else and try paid care abroad.

This life situation also reflects another aspect, where the state offers a universal scheme for families with a disabled member. However, the financial support is insufficient, so care work mobility, in this particular case, represents a coping strategy for the family's financial situation. In a context of social norms attributing care responsibilities to women and the 'familialistic' public-policy orientation in Slovakia, Lena's migration to Austria is possible as her family does not need intensive care. Her parents are in no need of care, as her mother is self-reliant and her father passed away. If the situation in the family worsens (e.g. her mother needs), Lena declares that she will perhaps stop commuting to Austria and return permanently to Slovakia, where she can find a job, although less-well paid (compared to what she currently earns in Austria) in order to care for her mother.

Another participant from Slovakia, 37-year-old Lucia, a mother of seven, works in Austria due to the availability and affordability of childcare services in her home town. Although her husband and relatives are taking over her responsibilities while she is abroad, she declares that she can work in Austria thanks to how kindergarten

and school are organised in Slovakia and also thanks to a nanny who has been helping her husband.

My husband takes care of the children while I am abroad. For the youngest [11 months old when she started with care work] I hired a nanny. So, he took the youngest to the nanny in the morning, the older children to school and in the evening he collected them. They had all-day activities, after-school activities – such as music class or painting – then he took them home at five. I paid the nanny 10 euros per day.

In this case, care work in Austria financially complements Lena's husbands' wages and the state-paid child benefits, which would not be sufficient to cover the family's daily expenditure. Lucia is thinking of quitting care work in Austria as soon as the children turn 18 and are self-supporting or if another major need for care in the family arises.

As this section has shown, the interviewed families made use of public care services to different extents. Some did not utilise any services, either because these were not available or because the family was not interested in the rather unsatisfactory public support and declared that they relied on the family's care resources instead of searching for institutional support. According to cultural norms, elderly members of the family should continue to live at home, being cared for by family members. Placing an elderly family member in a residential home is seen as inappropriate. Similarly, Romanian care workers who participated in our research declared that there is a generational obligation for them to take care of their elderly parents.¹⁵

7.7 Conclusions

Mobile care workers circulate between their respective countries of origin and work, being 'here and there' without necessarily intending to settle in the country of work (Morokvasic 2013). This chapter has shown that, despite commuting to Austria to work in care, these women remain responsible for the organisation of care in their own families – which tends to be rather sporadic, temporal and limited. The carers we interviewed referred to the main care needs during their absence as being sustaining basic services in the household and reproductive labour for the closest

¹⁵ A previous study on female care migration from rural Romania found that it led to shifting evaluations of institutional care. Through the particular example of two Romanian villages, Thelen (2015, 151) argued that 'the phenomenon of care migration to the West has changed perceptions of care institutions for the elderly', particularly with regard to institutional arrangements through which elderly people living alone are being cared for in their homes, with the support of the local community. Looking at a particular example of community-based elderly care, Thelen found that 'not sending the elderly out of their homes must be avoided, but they must certainly not be sent out of the village' (Thelen 2015, 152). As our research focused on care workers' strategies for addressing their families' care needs, we found that care workers feel responsible for caring for their elderly relatives. Furthermore, we found that, in addition to being their responsibility, care workers do not intend to place their elderly parents in institutional care.

family members such as children, partner/spouse or parents. The ways in which these needs are addressed, as our qualitative study has shown, are influenced by several factors – relationships between family members, family structure and type (e.g. nuclear family, extended family or double-generational family), length of shifts abroad, cultural norms and expectations towards women, spatial distance between family members' residences in the origin country and welfare provisions for care.

The high reliance of Romanian and Slovak care workers' families on informal care is also influenced by the cultural norms according to which the provision of care is the result of intergenerational solidarity and socially expected behaviour. Some narratives reflected on the strong social expectations. The mobile caregivers, the main carers in their families in the countries of origin, leave in order to undertake paid care abroad while the care needs within their families must be satisfied in different ways. The social construction of care and cultural values, together with gaps in institutional frameworks in the two countries, affect mobile caregivers' decisions. Care systems interfere with patterns of labour-market behaviour, including cross-border mobility. The examples in this chapter underline that, once the acute need for care for a family member appears, women no longer engage in care work abroad or they leave care work altogether and return home to take up their responsibilities caring for their own families.

Depending on the age of their children or the needs of their elderly parents left at home, the re-organisation of informal care within the family and accessing/utilising public services do not seem to differ in the two countries. However, the differentiating factors appear to be the time spent abroad and the commuting distance between their homes and the private homes where they work in Austria. We argue that the existing care needs in care workers' families facilitate this type of work; alternatively, mobility patterns influence the ways in which care needs at home are being addressed. Existing (limited) care needs that enable the reconciliation of family responsibilities and working abroad allow carers to engage in this transnational care work, as shown by the transnational care provision from Romania and Slovakia to Austria. The specific mobility pattern in the form of short-term commuting – 'back and forth' – enables carers to be involved in family care at home too. At the same time, women with extensive care obligations are less likely to migrate. As limited formal services put pressure on families to continue providing care informally, we argue that these institutional frameworks – particularly for childcare and care for the elderly – also influence care workers' mobility strategies.

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