Chapter 2
Care and Domestic Work

2.1 Not Just Another Job

The transnational migration of women (and some men) as domestic and care workers is based on the increasing expansion of a private market which is recruiting workers, mainly in the Global South, to perform tasks relating to reproductive labour in wealthier countries. To understand the experience of these workers, it is important to consider how this labour market differs from others. It cannot be reduced to payment for the performance of tasks. It is also undoubtedly affected by the private realm in which it takes place. Some scholars have argued that the uniqueness of this labour market lies in the intimacy that it is charged with, as a consequence of the physicality of care work, the privacy of the domestic setting in which it takes place, and the relevance of the interpersonal dimension it entails (Parreñas & Boris, 2010). Let us look more closely at these different elements.

Firstly, it's worth stressing that the content of the work – what is 'sold' – is a matter open for discussion. For some authors, workers are not simply offering the accomplishment of a task; they are 'selling a relationship'. For example, for Arlie Russell Hochschild 'love' is actually what is sold here, the commodified object at stake. We are confronted with an important example of what she calls 'emotional work' (Hochschild, 2012). For Hochschild, taking care of someone falls into a category of jobs based on a process of 'outsourcing of the self', meaning that care receivers expect their caregivers to be able to materialize their wishes, to understand those wishes and make them a reality (Hochschild, 2012). This can range from being tended to and assisted in the proper way, to receiving a nice meal and good company. As Encarnacion Gutiérrez-Rodríguez (2010) explains with reference to affect theories, these tasks equally affect the person who performs them and those who benefit from their performance. The activist for domestic workers' rights Ai-Jen Poo also emphasizes the importance of caregivers' capacity to provide emotional support to ageing people as something which needs more recognition (Poo & Conrad, 2009).

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As mentioned in the previous chapter, feminist sociologists such as Carol Wolkowitz (2006) have specifically reflected on the physical dimension of this type of work which is fundamentally based on bodily contact, as is the case for many other jobs performed by women in the health, care and service sector more generally. Such body work is usually associated with menial and strenuous jobs relating to cleaning, tending children, the elderly and sick people. In this perspective, such body-to-body work is very different from work done by machines or even work that entails human contact but not physical touching. Thus, it is very intensive work that demands not only physical strength but also attentiveness, emotional responsiveness and endurance, therefore putting workers at risk at both the physical and psychological level.

Therefore, the importance of the home as a very special place of employment emerges. In their interactions, workers and employers have to continuously renegotiate the boundaries between their working and personal lives. It is useful to examine this through the lens of feminist arguments on domesticity and the politization of the public-private dichotomy (Davidoff, 2003). It is in this 'politicized' domestic space that the relationship between migrant domestic workers and their employers can be interpreted: for instance, by looking at the way the domestic and care practices delegated from employers to workers are regulated by division along class, gender and racial lines, and therefore organized along axes of power. The home is thus the site where identities are shaped, contested, and reshaped over time. Similarly, Yeoh and Huang (1999) see homes where migrant domestic workers are employed as 'contact zones', while Janet Momsen (1999) talks about 'culture-contact situations'. Homes are very much shaped by national culture and identities. Blunt and Dowlings (2006) talk about homes in which discourses and practices related to nationhood are reproduced. In what they refer to as 'lived and metaphorical experiences of home', people create a sense of identity that then calls for an analysis of the power relations that make the home an 'intensely political' site.

In view of this relationship, I consider the home not simply as a 'space', but rather as a 'place', that is, a specific location where subjects' experience takes shape. The difference between space and place is emphasized by Doreen Massey, who defines a place as the result of particular interactions and of social relationships which occur in that specific location (Massey, 1994). For this reason, when looking at the interactions between employers and employees in the domestic sphere, one should see a place rather than a space, as it is a specific location where different forces interact. The domestic place where these encounters occur, practically and metaphorically, reflects the structure of the social space, where different subjects occupy a range of positions. In this view, the organization of these homes as workplaces is crossed by boundaries separating the middle and upper class in opposition to the working class, and European citizens versus migrant (often undocumented) workers. In fact, I consider these homes as crucial places where we can observe what has been called 'everyday bordering', with reference to the fact that an anti-migration attitude is not only about patrolling physical borders to reject migrants, but is also concerned with enacting separations between migrants and non-migrants in their everyday encounters, such at the workplace, hospitals or schools

(Yuval-Davis et al., 2019). When it comes to migrant domestic workers, private homes, as simultaneously their accommodation and workplace, are fraught with difficulties.

2.2 The Care Economy Debate

As we have seen, towards the end of the 1990s, scholars started to talk about the specificities of the market surrounding care and reproductive work once these became commodities, that is, like goods that can be sold and exchanged. Vivian Zelizer (2009) uses the expression 'economy of care' to refer to the specific market created by the delegation to others of tasks otherwise understood as private and intimate. The process of commodification of care has increasingly intensified through the years, investing more and more activities (performed both in private homes, hospitals and other residential facilities) and drawing on a growing workforce which, as mentioned, includes large numbers of migrant women.

An important author in this debate is Claire Ungerson. In 1997, she defined this process of commodification of care as the 'marketization of intimacy'. She described how, while in traditional economies the bulk of reproductive tasks was accomplished inside the household by (unpaid) female family members, in contemporary economies these activities are increasingly available on the market, from meals prepared by professional cooks that can be bought in restaurants, to the fact that elderly people can be assisted by paid caregivers in nursing homes.

This leads her to say that 'the commodification of care exists and is growing; we have yet to develop an adequate understanding of its implications for citizens, carers, and users' (Ungerson, 1997, p. 379). Importantly, Ungerson questions the meaning of this commodification process for our understanding of the nexus between care and gendered citizenship. She is concerned that 'the presence of money' will affect the nature of care relationships. Different views on differences based on class, race, and gender may also play a role in such labour markets (Ungerson, 1997, p. 379).

Other authors have highlighted the peculiar functioning of the care market: not a market in which goods are produced and exchanged, but a market based on service provision, where what is sold are 'relational services'. This view of care and domestic work as a service has a number of consequences and limitations. For example, for Susan Eaton it was difficult for caregivers to quantify in their bills 'the time to listen to somebody's story, time to hold their hand, time to comfort somebody who is feeling trouble' (Eaton, 1996: 7). In a similar perspective, Nicola Yeates (2004) makes a distinction between 'caring for' and 'caring about' to indicate the limits to commodifying care. If it is possible to quantify the work needed to care for something, it is more difficult to quantify (and require payment) for the work involved in caring 'about' someone. Indeed, the extent of commodification is constrained by the type of care labour involved ('caring about' not being amenable to commodification) as well as by cultural norms. Anna Yeatman (2009) is critical about thinking of

care as a service, since it is extremely hard to produce an assessment or to appraise the 'output' of the care provided. The question is essentially whether those who buy these services should be seen more as 'customers' or as employers or patients. If the term 'employers' implies centrality of the working relationship, and 'patients' indicates that care and wellbeing are the primary focus; then 'customers' places ultimate importance on the service dimension: that is, the satisfaction of the client (Cranford & Miller, 2013).

Another key author in this debate is Nancy Folbre. Her main argument centres on the distinction between the unpaid care typically provided in the family setting, and the paid care provided in a working relationship. She highlights that while love is usually considered a proper intrinsic motivation to perform care tasks, money, by contrast, is seen as a suspicious extrinsic reason to engage in it (Folbre, 2012, pp. 22–4). For Folbre, this dichotomy between intrinsic and extrinsic motivations permeates the entire realm of care provision considered as a service, explaining the paradoxes and tensions experienced by caregivers and care receivers alike. With other terms, Viviane Zelizer (2009) has already said that in the realm of intimacy, love and money are constructed as two 'hostile worlds'.

Moreover, Folbre argues that the care market is not like other competitive service markets for a number of reasons. She argues that care jobs rely on trust as their fundamental element, and it is the collaborative relationship between all the people involved that determines the quality of the service (Folbre, 2012, p. 35–6). Care-managers should find a balance between controlling workers and giving them freedom to accomplish their tasks as they wish, in a spirit of mutual collaboration and discretion. At the same time, she also draws attention to the fact that care recipients are often not capable of expressing their own satisfaction. This subverts the assumptions about the 'consumer sovereignty' that usually dominates in both customer services and in personal care (Folbre, 2012, p. 3). Folbre considers the intimacy that surrounds the provision of care for children, elderly people and sick people an obstacle to an exact quantification of the 'cost' of this type of labour, which goes well beyond a clear-cut relationship between assignments and outputs (Folbre, 2012, 3). In fact, care provision is also influenced by what William Baumol (1967) described as a paradox when the wages of workers are not based on their productivity, but on external factors that influence the value of the labour (Simonazzi, 2011; Yeates, 2009).

To sum up, many scholars deem the expansion of care markets detrimental as long as it promotes a reductive understanding of 'both care as a commodity, and the individual in need of care as a consumer' (Anttonen & Haïkiö, 2011: 71). In fact, many authors are critical of a vision of care systems as based on individual decision-making, that is, considering care receivers to be customers that shop around and make choices concerning care services as they would when buying other types of products (Glendinning, 2008; Shutes & Walsh, 2012; Stevens et al., 2011). Along these lines, Catherine Needham highlights how the 'personalization' of services has become the main narrative underwriting the public service reforms carried out from the 1990s onwards that promoted the privatization of care provisions and its

Box 2.1: 'Care Debates' in Latin America
Among feminists in Latin American countries, debates on care and reproductive labour have generated new productive concepts. Care issues are often translated as 'economías feminista, social y solidaria', to include all social activities (paid and unpaid) that contribute to society, are based on principles of reciprocity, and that emphasize social interconnections (Quiroga Diaz, 2009). Care and reproductive labour are often understood in more general terms as something that ought to be pursued as a social value. Since this is embodied by women, they should be respected and valorised.

Since the 1980s, feminist scholars in Latin America such as Mérola (1985) and Luz Gabriela Arango Gaviria (1997) have emphasized the question of reproductive labour. Another example is the special issue of *Iconos,* a journal edited by Vega and Gutiérrez Rodríguez (2014), with several contributions applying recent debates on care to different national contexts, like Claudia Fonseca and Jurema Brites's essay (2014) on Brazil, or Pascale Molinier and Luz Gabriela Arango Gaviria's (2014) work on Colombia.

outsourcing to non-state actors (Needham, 2011). Authors also warn against the easy dichotomy between unpaid care seen as rigid and inefficient, and paid care service seen as more flexible, efficient, and attentive to the needs of care receivers (Clarke, 2006). As I will discuss further in the following pages, this dichotomy tends to obscure the neoliberal shift by which citizens are turned into consumers, ultimately responsible for their own care needs, while states are limited to merely ensuring that private (care) markets work (Box 2.1).

2.3 A Transnational Care Industry

By adopting such a framework, we see how migrant care and domestic workers are increasingly filling the gaps in care provision in wealthier and industrialized societies through their (often irregular) jobs in the domestic sector and in care-related occupations. In other words, they are filling the gaps of what Fiona Williams (2011) defines as the 'transnational political economy of care'. This is a consequence of the fact that, as for example in Southern Europe, the increasing participation of women in the labour market has not brought about changes in the traditional division of roles within their families. Migrant women seem to substitute for local women in their traditional reproductive role. The old system of the gendered division of labour has simply been maintained or reproduced through a new supply of labour along racialized lines (Andall, 2000). In fact, as mentioned in Chap. 1, the international division of care work reveals the importance of the intersections between gender and other social categories, such as race/ethnicity, class, age, and so forth (Anthias

& Yuval-Davis, 1992; Guillaumin, 1997). Furthermore, we have seen how, since the new migratory flows are taking place in the context of increasingly fortified boundaries, this also means that in some contexts, domestic work is becoming one of the few available channels for regular migration for women. Studies have shown how the articulation of immigration policies with social policies creates a gendered and racialized division of labour (Gallo & Scrinzi, 2016; Lutz, 2008).

However, recent developments of scholarship in this field have highlighted the necessity of broadening this analysis by investigating other social actors who have a stake in the issue of migrant domestic labour. Up until this recent development, most studies have focused on the traditional forms of domestic service in the private sphere; by contrast, Eleonore Kofman (2012) stresses the importance of incorporating into the analysis other agents of social reproduction besides the household, such as the market and the non-profit sector. She points out how the international division of care takes shape in the care industry providing home-based services for the elderly. Such commodification of care work at the transnational level is considered to be responsible for increased levels of inequality and exploitation (Williams, 2011; Yeates, 2009).

In this view, Nicola Yeates (2004) discusses the private provision of various types of care work, emphasizing the importance of strengthening the linkages between the concepts of the 'global care chain' and the 'global commodity chain', at least at the theoretical level. The challenge, for Yeates, is to go beyond the case of migrant domestic and care workers, to look at more actors – especially corporate care providers – and forms of outsourced service work, depending on what prevails in each context and historical period. Expanding the analysis to the role of corporate providers seems useful in understanding growing phenomena such as the transnational recruitment of nurses and doctors due to the privatization of formerly public health and care services in industrialized countries which are now in search of a cheap, flexible and yet highly skilled workforce (Connell, 2008; Kingma, 2007; Näre & Nordberg, 2016; Yeates, 2004). Yeates further develops her argument, speaking about the emergence of a corporate care industry, with particular reference to the US. As she puts it:

> care corporations provide a range of personal health and social care services in institutional (hospitals, nursing homes, nurseries) and domestic (households) settings; house care corporations provide private households with various 'housewife' services and maintenance, pest control and repairs. Corporations may specialize in one of these types of services or may combine different types of services (e.g., personal and house care). (Yeates, 2004, 382).

Yeates sees 'the corporate care industry [as] a major area of economic growth and employment generation' (ibid.) in many countries, even though public and informal providers remain a significant source of less profitable and non-profitable care services. In summary, Yeates offers a broad concept of care corporatization, which includes a wide range of for-profit suppliers; from self-employed individuals, to small enterprises, to agencies and multinationals. Accordingly, she charts the differences between various corporate care actors in terms of their size and the reach of their commercial activities, from the sub-national to the national and international

scales (Yeates, 2004, 382). In the next section, I highlight the kinds of imageries which are associated with such care arrangements.

2.4 Imageries of Care

In our article on the emerging corporatization of care, Sara Farris and I introduced the notion of 'imageries of care' to account for a further dimension of the various kinds of social organization of care on the basis of national differences, in this complex landscape (Farris & Marchetti, 2017). With this concept we wanted to tackle what ideas prevail concerning who is considered responsible for care provision and what responses are considered most suitable, in each context. A given group can be more inclined to think that care should be provided for free and organized by the state in institutional settings, while others may think that care is too intimate, and it can only go through a personal relationship, whether paid or paid, but certainly provided in personal and home-based forms.

Ideas such as the latter can be found in contexts where the familial model of care still prevails (Farris & Marchetti, 2017). At the practical level, we show how this model fails to take into account the concrete aspects concerning the modality, duration, and tasks of the assistance provided, in a one-to-one and very personal setting. Such imagery is associated with the realities of caregiving within family settings, mostly by female members, women and girls, in charge of fulfilling all reproductive tasks to support the entire household, notably taking care of children and elderly or sick relatives. Although one may think that this configuration is a legacy of the past, in our view this 'familial imagery of care' in fact still prevails today, even in settings where commodification is quite developed and caregivers are paid workers. In this situation, they are employed by the household of the care receiver and expected to offer a caring relationship which emulates the one existing between family members. As we will later see, this model has a strong influence on the employment experiences of many of the migrant women working in the transnational care market, especially in countries where a family-based social structure predominates.

At the opposite end of the spectrum of these ideal types of care imageries is the one we associate with the increasing marketization of care which, as Farris and I argue, may reach the point of a corporatization of care services (Farris & Marchetti, 2017). In these situations, care is understood as a highly structured activity, articulated in well-defined tasks with a specific duration and clear methods of provision. This type of imagery is spreading in national contexts where institutional residential homes are more common, or where home-based care is organized via agencies. In these care settings the one-to-one care relationship no longer prevails, since multiple caregivers rotate in shifts to attend to the same person. Their work is organized according to rigid schedules and forms of control, which makes it necessary to unpack complex activities into easily quantifiable tasks, to which the payment for these jobs corresponds. Such imagery is increasingly common in countries with ageing populations where the employment of caregivers is not directly managed by

households, but rather via private agencies or public-private institutions. Therefore, as we say:

> by turning it into an activity that is ever more codified, less personalized, poorly paid and less sensitive to the changing needs of the people towards whom it is oriented … care work is becoming the contested territory for the penetration of new forms of capitalist restructuring (Farris & Marchetti, 2017, p. 127).

Such settings are becoming common for migrant workers, as long as these employment services continue to seek an increasingly qualified workforce through recruitment abroad, due simultaneously to the lack of a national workforce for these poorly paid and precarious jobs, and the increased demand for care in industrialized, ageing societies.

Exploring the difference in the imageries of care between countries, in Triandafyllidou and Marchetti (2015) we have identified some regional patterns across Europe. There is, first of all, a pattern typical of northern and post-soviet European countries where institutionalized care is preferred over home-based care. In this setting, the private employment of care and domestic workers is seen as a challenge to ideals of equality, exacerbating class differences between women (Kristensen, 2017; Radziwinowiczówna et al., 2018). By contrast, in southern European countries care is provided inside the home by family members, notably women. Here, deciding to delegate care work to another person is often experienced as a necessary practical arrangement, yet fraught with moral and emotional distress due to feelings of disappointing expectations of mothers, wives or daughters (Marchetti, 2015; Vega Solís, 2009). Similar patterns concerning the impact of the national culture of care on employment relationships can be found in countries outside Europe. Along the same lines, research has shown that employers' attitudes towards the delegation of care and domestic tasks are of paramount importance in shaping employment relationships, from South Africa (Galvaan et al., 2015) to Yemen (De Regt, 2009) and Singapore (Lundström, 2013).

Moreover, it is important to ask oneself whether the delegation of care work to others has itself changed the way care is understood. Already in 1997, Ungerson noted – on the basis of interviews with care receivers to the elderly – how the possibility of cash payments has changed their understanding of care to something that was not obvious, not 'for free' (Ungerson, 1997).

However, caregivers are not all the same. There is a division between the role of the paid worker as the one in charge of everyday face-to-face interactions (Folbre's 'interactive care'), and that of unpaid caregivers (usually a female relative) who care more generally for the physical and psychological wellbeing of the care recipient (Marchetti, 2015). Similar worker-employer relationships have been observed in the field of private childcare, where working mothers think of themselves as those in charge of the education and wellbeing of their children, although the everyday care tasks may be covered by a (migrant) woman in their employ (Anderson, 2000).

This corresponds to a transformation in the way we see the role of mothers, daughters, and so on in households that employ a private caregiver. As Cristina Vega Solís (2009) argues for Spain, the increase in paid forms of care work transformed

the lives of the daughters of elderly parents, enabling them to delegate tasks that would traditionally be performed by themselves, so that they went from being caregivers to care managers. In Italy, Maurizio Ambrosini (2013) also emphasizes the crucial role of employers in paying the care worker's wages and discussing contractual conditions, regularizing the legal status of migrant employees (when they are undocumented), administering medicines and special treatments to the elderly, and providing instructions about meals, rest times and outings for the elderly individuals. In today's care arrangements, care managers require many skills to satisfy the needs of recipients, relying on any available public or private resources, and navigating the private market of domestic work and care work to employ a suitable caregiver (Marchetti, 2015). In this view, employers are indeed pivotal actors in setting the conditions of the rapidly expanding market economy which is developing around the care and domestic labour sector. Employers find themselves torn between the demands of the family and the market when assessing the care which is needed and the resources required; they either buy care or mobilize their own time and energy to provide it. In other words, there is a very thin line separating the role of these employers as family caregivers from that of market actors, since they can afford to delegate this same care-giving to a paid worker. In that case, employers have to juggle meagre welfare allowances or service provisions for the elderly or children with rising care needs (particularly of the elderly in Europe's ageing population), while women are increasingly engaged in full-time paid work outside the home (Triandafyllidou & Marchetti, 2015).

In Triandafyllidou and Marchetti (2015) we argued that employers of paid domestic workers may be classed into two main categories: employers as agents of social change, and employers as preservers of traditions. The first category includes employers such as the working mothers of young children or the daughters of elderly parents. For these individuals, hiring a domestic worker/babysitter/carer for the elderly is a way to pursue new models of parenthood and family life that do not of necessity entail a long, daily, physical commitment towards their family members. One may speak of the search for a 'modern' version of domesticity that combines responsibilities towards loved ones with paid work and a professional career, inevitably reducing the amount of time spent as the *materfamilias* in the home.

The second category of employers includes those who have to delegate the actual performance of care and domestic work to paid workers, but who would probably prefer to do the work themselves. Lack of time and energy, distance from their children or parents, and commitments to other family members are usually the reasons why these employers cannot directly take charge of the care of their relatives or even clean their own apartments. Thus employing someone is a second-best option, but it comes at the cost of feelings of guilt or betrayal. This type of employer expresses discomfort in the employment relationship. In so doing, they put forward traditional views on commitment towards their households which is ultimately detrimental to the relationships with the women to whom they delegate parts of their mothering and care duties.

2.5 Differences Between Countries

Today, how the commodification of care for elderly people, sick people and young children is organized – and in some cases supported – by public measures, differs from country to country. In fact, authors speak of conflicting tendencies within the political economy of care depending on the context (Esping-Andersen, 1999; Mahon & Robinson, 2011). In the past, there was a more distinct range, from systems that traditionally relied on non-paid care from family members (particularly women), to countries where such assistance was, partially at least, in the hands of the state. They range from the informal hiring of a migrant domestic worker (live-in or live-out) in the home, as is common in Italy, Spain or Greece; to the hiring through formal care schemes managed by private agencies authorized by the state, as often happens in the UK; to receiving services directly organized by state agencies, as is the case predominantly in Sweden or the Netherlands. One may also notice that the latest trends in the field of care provision for children, elderly and/or disabled people in Western Europe are increasingly following in the footsteps of the Australian and North American examples, in opening to for-profit care providers of various sizes and their adoption of profit-oriented business models in the management of service provision and human resources (Farris & Marchetti, 2017).

Another important context-dependent factor concerns the 'culture of care', which differs from country to country (and sometimes even within the same country). Indeed, as Francesca Degiuli (2010) emphasizes, the decision by care receivers to turn to private employment in home-based care cannot simply be explained by the greater or lesser availability of services and structures. It is rather based on shared cultural values and care traditions. For example, Pei Chia Lan (2018) notes that in the Asian context, the persistence of cultural norms that care for ageing parents will be provided 'in-house' by female family members is a notable impediment to the outsourcing of care.

The different modality of these arrangements can be tackled by the metaphor of the 'care diamond', which Kofman and Raghuram (2015) first introduced to explain how different actors, each placed at a corner of this diamond figure, contributed to shape the actual form of care provision. These actors were identified in the household of the care receiver, the state through welfare provision, and the not-for-profit sector, which through religious or other local voluntary organizations used to provide assistance to needy individuals. These actors were seen as distinct and mutually exclusive. However, this separation now seems to have faded away, especially since states are increasingly in favour of involving more actors.

This perspective helps us to understand the relationship between the welfare state and the 'refamiliarization' of those care commitments in the 1980s and 1990s that in some countries had previously been taken up by the state. This refamiliarization has not led to the re-establishment of previous systems of unpaid care provision, rather it has created a massive demand for privatized services because families have not (or not fully) returned to the traditional care model. They have started to outsource at least part of their care commitments (Ungerson, 1997). As Pavolini and

Ranci (2008) later observed, during these decades there has been 'a progressive decrease in the ability of family networks to provide support owing to the increase in the old age dependency ratio and the female activity rate' (p. 246). The combination of these processes of privatization and refamiliarization did unsettle the borders between the different European welfare regimes, according to Esping-Andersen (1996).

In other terms, households today are using their own family budget in order to purchase market-based services that had previously been provided by public nurseries, rest homes and hospitals, or that had been performed by members of the household itself (usually women). The problem is that when assessing the care which is needed and the resources available to acquire it, these households are often torn between the demands of the family and the functioning of the care market. For this reason, as mentioned before, it is important to think of employers as also caregivers, at least for the tasks which – for different reasons – are not delegated to a paid carer.

An overview of some care settings around the world will show that in countries like Italy, France and Belgium, there is a strong intervention by the state in supporting employers to individually 'buy' care service through allowances for families with disabled and seriously ill members, or young children. In Italy, this has been seen as an incentive for the emergence of what has been called a 'migrant-in-the-family' model whereby families become direct employers of migrant care workers (Ambrosini, 2013; Degiuli, 2010).

In Germany, the state intervenes in supporting the functioning of the market by emphasizing the role of employment agencies and other intermediaries specialized in this sector. In the UK, there is a divided market: since affluent families receive no allowances, they resort to private agencies from which they hire care workers, while working-class families who are recipients of cash benefits payments use it to cover general family expenses and only to a smaller extent to employ a private caregiver (Van Hooren, 2012).

Outside Europe, scenarios vary. In East Asia, countries like South Korea and Japan have a long-standing tradition of an institutional approach to care services and are reluctant to incorporate foreigners in their workforce on nationalistic grounds (Lan, 2018; Peng, 2017). Hong-Kong and Singapore, by contrast, have very personalized conceptions of care provision, with high levels of employment of foreigners within a liberal market approach (Peng, 2018), similar to the European migrant-in-the-family model. Halfway between these approaches is Taiwan, which has a tradition of public provision of healthcare and elder care, and yet when it comes to care for the elderly and disabled mainly relies on a liberalized system of intermediary agencies to employ migrant workers (Cheng, 2003; Lan, 2007).

Something different happens in the two countries that are considered the largest employers of domestic workers, Brazil and India, with a tradition of service work provided by girls (and some men), internal migrants, or ethnicized groups. This also happens in other places such as Ecuador, Bolivia and the Caribbean (Herrera, 2016; Martelotte, 2016; Masi de Casanova, 2013), south and central African countries (Ally, 2009), China, and South Asia (Neetha, 2018; Peng, 2017). Here domestic workers often live together with employers' families for many years, to satisfy their

care needs as they change through various life stages: from taking care of children, to caring for the elderly.

A different model is in place when a foreign worker is employed for a limited number of years, with the explicit function of taking care of children before they grow up, or of elderly relatives in the final years of their life. This model is the same in very different places, from Canada and the US (Michel & Peng, 2017; Romero, 2018), to Lebanon, Israel and Middle Eastern countries (Fernandez et al., 2014; Liebelt, 2011; Ozyegin, 2010), to countries in the European Union. The implications of this model in its interconnection with international migration policies will be explored below, in relation to the question of the home as a site of governance of migration (Box 2.2).

Box 2.2: The Corporatization of Care in the United Kingdom, Sweden and Italy

The transformations in welfare and care provision in industrialized countries with large, ageing populations can be seen in the light of what we call the corporatization of care (Farris & Marchetti, 2017). Looking at the the examples of the United Kingdom, Sweden and Italy, we see how this process has taken place in countries associated with very different welfare models, care regimes and political traditions, which have been labelled respectively *liberal*, *social democratic* and *familistic* (Esping-Andersen, 1996).

The main differences between them can be summarized as follows:

- The United Kingdom: the elder care and childcare sectors are dominated by for-profit actors.
- Sweden: corporatized care is almost exclusively confined to the elder care sector, while the childcare sector is still mostly run by the state, or outsourced to not-for-profit actors.
- Italy: the presence of for-profit companies in the care sector is traditionally very limited, both in the case of elder care and childcare, where the not-for-profit sector or commodified forms of home-based care prevail.

Despite these differences, in all three countries the number of for-profit care providers has grown at a dramatic pace over the last decade. Even though the presence of for-profit companies is still very limited in Italy, or is confined to the elder care sector in Sweden, their exceptional expansion into the space in just a few years speaks of significant developments in investment in the care sector.

2.6 The Role of States

We may say that generally, the role of states in this realm is highly problematic. Increasingly since the 1990s, states have encouraged the marketization of care by relegating its provision to the private care providers and relying on competition among them. During the same period, as Tseng and Wang (2013) argue, states have been able to progressively delegate to employers (that is, care receivers) a series of important commitments and responsibilities which are vital to the functioning of the system. In Clare Ungerson's (1997) view, the 1980s and 1990s mark the crisis of welfare and the consequent refamiliarization of those care commitments that had previously been fulfilled by the state. This refamiliarization has created a demand for privatized services, since families are no longer able (or willing) to satisfy all the care needs of their households to the extent that they were in the past, and have therefore started to outsource at least part of their care commitments.

In Europe, care is probably the welfare sector that has been most privatized by state reforms in contrast with health, education, pensions and so forth (Daly, 2012; Ferrera, 2005; Graziano et al., 2011). The way European states are doing this varies greatly from country to country, with different policy approaches in place (see Picchi, 2016). In fact, since the 1990s, several Western European countries have reformed their long-term care system and promoted home-based care as a way to save on social care costs. In some countries there is a strong intervention by the state in supporting employers to buy the service by means of the monetization of allowances for households with disabled and seriously ill members, or for households with young children. In other cases, the state intervenes in supporting the functioning of the market by emphasizing the role of agencies, as we will discuss more in detail in Sect. 3.6. Thus we see how the role of states is central to making some market actors more influential. Governments are those who 'authorize, support or enforce the introduction of markets, the creation of relationships between buyers and sellers and the use of market mechanisms to allocate care' (Brennan et al., 2012, 379).

In other words, states have withdrawn from being direct providers of care, but they still retain other functions which greatly influence this sector. First of all, states have an important regulatory function, which explains why 'the commodification of care has gone hand in hand with an increase in public coverage and public regulation' (Pavolini & Ranci, 2008, p. 247). States are providing the normative framework and work regulations that allow private companies or individuals to offer their services within the households (Da Roit, 2019; Estévez-Abe & Hobson, 2015; Shire, 2015).

It is also worth noting, as Pavolini et al. (2012) point out, that these transformations in the role and function of state in care provision occurred in parallel to a reorganization of the 'level' at which decisions concerning these issues are taken. In countries like Italy, a progressive decentralization of state functions has had important repercussions on social services, health, education and welfare generally (Ferrera, 2005). Local public authorities such as regions and even municipalities,

today have full powers in these realms. They are in charge of finding affordable, feasible and yet innovative solutions for the provision of services such as personal care for elderly and disabled people, despite the cutting of funds which limit direct public intervention in this field. In this scenario, local not-for-profit organizations such as cooperatives and associations become important allies by offering – at low cost– the means and structures to pursue new social policies.

There are a number of mechanisms through which the state can frame the emergence and functioning of a private care market. In Triandafyllidou and Marchetti (2015), we provide an overview of such mechanisms for several European countries. In the first place, states may introduce intermediaries in working relationships, such as employment agencies. An example of this is the voucher system which was introduced in Belgium in 2004, a policy of housework vouchers (*titres-services*) which allows households to officially purchase weekly housework services from an authorized agency (Camargo, 2015). Secondly, states can enforce specific occupational measures to promote (and influence) the private employment of domestic and care workers. Particularly relevant is the case when states take advantage of the growth of care market-services to channel unemployed local women into this work sector (Humer & Hrženjak, 2015; Van Walsum, 2011). Finally, states strongly intervene in the care market with explicit policies for the recruitment of migrants. I will come back to this in the following chapter of this book. For now, we can briefly mention au pair employment schemes (Cox & Busch, 2018; Kristensen, 2015; Pelechova, 2015), amnesty for undocumented migrants employed in this sector, and the establishment of bilateral agreements with countries of origin for recruitment in this field. The composition of the labour force will have a different character depending on existing bilateral agreements, including pre-departure training programmes and quota-based policies concerning workers' countries of origin (Kofman & Raghuram, 2015). Thus, states are important actors in dictating the rules and conditions of migrant workers' recruitment, which is of paramount importance today, given the high percentage of international migrants employed in all forms of care provision.

On the intertwining of state policies on welfare and migration, and the corresponding care market, Franca Van Hooren (2012) has offered the following three examples from Europe. She argues that different welfare systems lead to different types of migration, care arrangements and specific 'care markets'. First of all, she highlights the Italian 'familialistic care regime', which provides cash allowances to families, giving incentives for the emergence of a 'transnational market familialism' (Näre, 2013) or the migrant-in-the-family system (Bettio et al., 2006) whereby families become employers of migrant care workers. Secondly, we have the British care regime, where care is increasingly transformed into cash payments, with strong inequalities affecting the resulting care service market. More families receive no payments and hence resort to a private agency care market from which they hire care workers. At the same time, those families that are recipients of the Attendance Allowance (AA) in cash use it to cover peripheral costs like transport, food and fuel, while they rely on adult family members, friends and only to a smaller extent on professional care services for the actual care work. The third and last example is the

Dutch welfare system, which relies on the provision of care services that are publicly financed. Thus individuals rely on the public system for personal care, or on family members. There is no market for privately purchased personal care services and thus the demand for migrant care workers is very low (Van Hooren, 2012, p. 142).

Barbara Da Roit and Bernard Weicht (2013) find that Germany, Austria, Italy and Spain rely mainly on migrant care workers employed in the household, while the Netherlands, Norway, Sweden and the UK tend to rely more on the formal sector and on services provided by public organizations or private companies. Thus, they partly confirm the distinction introduced by Van Hooren (2012) between familialistic care regimes leading to migrant-in-the-family care models, and liberal regimes leading to migrant-in-the-market models. They indeed show that the migrant-in-the-family model adopted in Austria and Germany is the result of limited publicly available services, cash-for-care programmes, and the segregation of migrants in low-skilled jobs (Da Roit & Weicht, 2013, p. 479).

Da Roit and Weicht find that the segregated labour market and the presence of undocumented migrants willing to work as domestic workers are sufficient factors leading to a migrant-in-the-family model even in the absence of generous cash-for-care benefits (for example in Italy and Spain). At the same time, they find that while the absence of uncontrolled cash benefits and of a large informal economy are strong predictors of a migrant-in-formal-care model as occurs in the Netherlands, France, Sweden and Norway, they are not sufficient conditions. For example, the UK satisfies these conditions but is characterized by a strong presence of the private sector and formal care arrangements through private providers. It is probably a combination of the public expenditure on formal care services with the absence of uncontrolled cash-for-care programmes and the absence of an informal economy of care that leads to the specific national care model. Different 'care packages' are available depending on the context, and employers choose between various combinations of care services (Da Roit, 2010).

Another example of the overlap between state and markets in care provision is what we can call bureaucratized care, organized in a very different way from that based on private employment by individual households. Today this tendency is common in northern European countries such as Denmark (Cancedda, 2011), the Netherlands, Sweden, Norway (Da Roit & Weicht, 2013) and the UK (Shutes & Chiatti, 2012). Whether it is in a company or in the non-profit sector, bureaucratized care work is characterized by the intermediary role of care providers who act as employers of the care workers; they are responsible for recruiting, managing and organizing the work. Bureaucratized care work usually involves a collective dimension (that is, the organization of workers in teams) and some monitoring and tutoring provided by managers. In contrast to the one-to-one relationship between employer and employee in traditional home-based care, these care workers can be assigned to any of the care provider's clients. Finally, domestic chores tend to be organized on the basis of industrial criteria, as a certain amount of time is allocated for each task and each service provision is planned with cost-efficiency in mind.

Such emphasis on bureaucratized and industry-like forms of home care provision indicates that it is necessary to investigate the interaction between the multiplicity of actors that today intervenes in the realm of the commodification of care, such as private companies, not-for-profit cooperatives, public authorities, and so forth, and thus to broaden the perspective beyond the family as the realm of care (Kofman & Raghuram, 2009; Näre & Nordberg, 2016; Williams, 2010; Yeates, 2009). In a wider perspective, and following Clare Ungerson (1997), it is also important to look at these developments from the perspective of gender, race and class differences.

Responding to these debates, in Marchetti and Scrinzi (2014) we focused on migrant workers in bureaucratized settings, namely not-for-profit social cooperatives that provide home-based care services for the elderly in Italy. We documented both the application of bureaucratized and industry-like logics to the daily administration of not-for-profit care providers, and how the racialized and gendered profiling of workers plays a role in this type of organization. Indeed, it is important to draw attention to how, in bureaucratized care provision in Europe, the racialization and feminization of these jobs continues to shape the conditions for the large-scale employment therein of women with migrant backgrounds.

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