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In memory of Vern L Bengtson, who was a member of the IJAL Editorial board since the journal started in 2006. Vern Bengtson was a professor of social gerontology, social work and sociology and had a long research career in family gerontology that spanned over 50 years in the University of Southern California, USA. He initiated the longitudinal study of generations, which explored the dynamics of four successive generations. He was also one of the founders of the theory of family solidarity, one of the most influential theories in intergenerational research. He became 78 years old and devoted the end of his career to research on religion and the transmission of religious values between generations, reflected in his books "Families and Faith. How Religion is Passed Down Across Generations" (Oxford University Press, 2017), and "New Dimensions in Spirituality, Religion, and Aging" (Routledge, 2018). He authored 260 articles and 19 books on gerontology and was recognized in his research by many awards. He wrote the Guest Editorial "Theorizing in Social Gerontology" in the first published number of IJAL 2006, where he explained and de-mystified theory, and described theory as a game or a puzzle.

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Transnational mobilities of care in old age

By *VINCENT HORN*¹ & *CORNELIA SCHWEPPE*²

The world's population is ageing. Particularly industrialised countries in Europe and elsewhere are experiencing rapid growth in the number and proportion of older people in their societies. The economic and socio-cultural challenges that population ageing poses to labour markets, welfare states and families in Europe have been dealt with extensively (e.g. Harper 2016). An area in which different challenges conflate and reinforce each other is that of long-term care (LTC) in old age. "LTC in old age" refers to all kinds of formal and informal care and support services provided to older people on a regular basis. LTC in old age is provided in different settings (at home, in day-care and short-stay services or in LTC facilities) by a network of care providers, including the family, public services, market-based and third sector organisations. With more people living longer, the demand for LTC services in old age is projected to rise steadily across European countries, raising concerns about the fiscal sustainability of LTC systems (Greve 2017). Other societal changes, such as the increased participation of women in the labour market, put additional pressure on policy-makers to find affordable solutions for the delivery of good quality LTC services tailored to the diverse needs of older people.

European countries are responding to the growing need for LTC against the backdrop of very different traditions and institutional contexts.

¹*Vincent Horn*, Institute of Education, Johannes Gutenberg University Mainz, Mainz, Germany.

²*Cornelia Schweppe*, Institute of Education, Johannes Gutenberg University Mainz, Mainz, Germany.

Thus, diverse LTC systems exist with varying financing systems, conditions of eligibility and access to LTC services, and distribution of responsibilities for LTC in old age between the family, the market and the state (Bettio & Verashchagina 2012; Colombo et al. 2011). According to Anderson (2012), a spectrum of care provision can be found in Europe, with the “informal care-led model” at one end of the spectrum and the “service-led model” at the other. In the former, the state’s responsibility is mainly regulatory whilst the provision of care relies heavily upon the family. In contrast, the service-led model reduces the responsibility of the family by offering a wide range of publicly funded care services. Based on similar considerations, van Hooren (2012) distinguished between three ideal types of LTC systems in Europe: the social democratic, the liberal and the familialistic models (van Hooren 2012).

In the social democratic model, represented by the Netherlands and the Nordic countries, the state assumes major responsibility in the form of high public expenditure and the provision of a relatively generous public LTC infrastructure. Private expenditures tend to be low and cash benefits, if available, tightly regulated. Despite the great availability and affordability of LTC services, the family still bears the brunt of LTC in these countries, although less in the form of hands-on care than of practical and emotional support. Compared to the state and the family, the market still plays a minor though increasingly important role in the provision of LTC services. By contrast, in the liberal model, represented for example by the United Kingdom or Switzerland, the market is an important provider of LTC, especially with regard to residential care but also increasingly in the home-based care sector. Families are the main providers of care in both practical and financial terms. High-income households, especially, have to shoulder large expenditures for LTC as cash support from the state tends to depend on means testing and asset assessments.

As already indicated by its name, in the familialistic model, the family is also the most important provider of LTC (Bettio & Plantenga 2004; Esping-Andersen 1999). In this model, families to a greater or lesser extent receive cash support from the state when caring for older relatives themselves (Leitner 2003). The use of these cash benefits is not usually regulated and thus can be spent at the discretion of the older people in need of LTC and their families. In-kind allowances, by contrast, are paid when professional LTC home-care services or LTC facilities are used. However,

in-kind allowances function like a partially comprehensive insurance; relatively high private co-payments are the consequence. Compared to the social democratic model, the public LTC infrastructure is less developed and mainly provided by third party and for-profit providers. Countries with familialistic LTC systems differ with regard to the level of state support. The latter is more generous in countries like Austria or Germany and less generous in countries like Spain, Italy or Greece.

Despite these differences, a certain convergence in the provision of care across European countries has been observed (Simonazzi 2009; Williams 2012). To keep public expenditure low, LTC systems have increasingly been opened to the market and steps taken to promote (comparatively cheaper) home-based LTC arrangements. Measures undertaken to achieve this goal include the tightening of eligibility criteria for residential care and the fostering of informal home-based care through cash-benefits or paid elder care leave. On the one hand, the trend towards the marketisation of LTC has increased the demand for cheap care labour in many countries. However, low status and low pay as well as precarious employment conditions (e.g. long working hours, shift work) make working in the LTC sector less than attractive. On the other hand, the fostering of informal LTC arrangements has increased the risk of overburdening family carers. Not only have changing gender roles diminished the resources of families to provide LTC, with labour market participation having become a natural component of women's life scripts, but the type and duration of LTC needs have also changed, with conditions such as dementia posing specific LTC demands whilst making it difficult to anticipate how the situation will develop and how long it will last.

The shortage of LTC workers, the inadequate quality of care provided in LTC facilities in addition to high costs, overburdened family carers and the (image of) exploding public expenditures are some of the core ingredients of Europe's elder care crisis.

In tackling this crisis there is widespread evidence that countries are increasingly resorting to solutions that go beyond the single nation-state. In this regard, the reliance on migrant care labour is already evident in many European countries today. LTC workers with a migration history make up substantial proportions of the LTC workforce in many European countries (IOM 2010; Rada 2016). Germany, for example, has launched programmes to recruit LTC workers abroad in the past, and is currently

intensifying its efforts to attract LTC workers from Mexico, Vietnam or Namibia in order to reduce the calculated gap of 40,000 positions in the country's LTC sector (Dohnhauser 2019). The example of Germany is part of a process in which relatively rich countries compete for LTC workers originating from lower-income countries. The increasing diversification of source countries indicates the globalisation of the competition for LTC workers, with all its possible implications ("care drain", "brain drain") for the LTC workers' countries of origin discussed in the literature (Bahna 2015; Gheaus 2013; Hochschild 2002; Raghuram 2009). However, the demand for migrant LTC workers differs across European countries, as do their employment conditions and the sectors into which they are primarily incorporated.

Researchers have emphasised that the scope and incorporation of migrant LTC workers is closely related to a country's LTC system (Anderson 2012; van Hooren 2012; Da Roit & Weicht 2013). According to the literature in this field, the demand for migrant LTC workers in countries with a social democratic LTC model is rather low and particularly driven by public not-for-profit and private LTC providers in the formal labour market. The employment conditions of migrant LTC workers appear to be similar to those of the native workforce. In the liberal model, migrant care workers are predominantly recruited and employed by private LTC service providers (Cangiano & Walsh 2014; Shutes 2012). The employment conditions of migrant LTC workers in the liberal model tend to compare unfavourably to those of the native workforce in both the private and public LTC sectors (Lightman 2019; van Hooren 2012). Since migrant care workers are particularly incorporated into the private LTC sector, van Hooren points out that a "migrant in the market" model of employment has emerged within the liberal LTC model.

With regard to the familialistic model, Bettio and colleagues (2006) pointed to a transition from a family-based to a "migrant in the family" model in Southern European countries. In the absence of adequate LTC services, families in Italy and Spain were shown increasingly to be hiring live-in migrant carers (LIMCs) to care for frail and elderly family members (Degiuli 2016; León 2010; Skornia 2014; Tobío & Gorfinkiel 2007). LIMCs are migrant women (and men) who live permanently or periodically in the same household as an older person in need of LTC, performing a diversity of tasks, including care activities and domestic chores.

LIMCs in these countries are of diverse origins, including Latin American countries, Eastern European countries and the Philippines, and their migration status varies considerably across and within national groups. Whilst LIMCs are particularly prevalent in Southern European countries, the number of LIMCs in Germany and Austria has increased significantly as well (Krawietz 2014; Österle & Bauer 2012). LIMCs in these countries come primarily from neighbouring Eastern European countries such as Poland or Slovakia but also from more distant countries such as Croatia, Hungary or Romania.

Theoretically, the global intersections between (gendered) care, migration and welfare regimes have been conceptualised in various ways. With the concept of global care chains, Hochschild (2000) famously linked global inequality structures with the transnational connection of households at the micro-level. According to Hochschild (2000: 13), a global care chain is typically formed by “an older daughter from a poor family who cares for her siblings while her mother works as a nanny caring for the children of a migrating nanny who, in turn, cares for the child of a family in a rich country.” The focus on nannies and maids has been expanded to incorporate other tasks and occupations performed by migrants in the global care economy (Isaksen 2010; Yeates 2005). Sassen (2002) introduced the concept of “survival circuits” to analyse the conditions and dynamics leading to the global migration of women as care and domestic workers, sex workers, nannies and so forth. Finally, Williams (2011) used the term “transnational political economy of care” to explore the interrelationships of Europe’s care, employment and migration regimes.

While the employment of migrant care workers has become a widespread approach to face the challenges of LTC, still another development can be observed, though on a less pronounced scale. Instead of moving “carers in”, people in need of care are being “moved out” (Horn et al. 2015). This development is manifested in the establishment of care facilities abroad, mainly in low-wage countries, targeted at older people needing care in richer countries. This development can be observed in South East Asia (Thailand, Malaysia, the Philippines), for example, where old age care facilities have been established for older people in need of care from central European countries or from Japan, or in Eastern Europe for older people from Germany.

Focusing on transnational mobilities of care, this special issue inquires into the political and socio-cultural factors leading to the emergence and persistence of cross-border mobilities caused by the demand for LTC in relatively affluent ageing European societies. It specifically asks for the implications of these cross-border mobilities for micro-level interactions.

In taking the examples of Germany, the Netherlands and Switzerland, three very different LTC systems are discussed. All three are experiencing growth of LIMC arrangements, although to very different degrees. In the publicly supported familialistic German LTC system, LIMC arrangements are already a widespread phenomenon (Arend & Klie 2017; Neuhaus et al. 2009). By contrast, in the rather liberal Swiss LTC system, LIMC arrangements have only been on the rise for a couple of years (van Holten, Kasper & Soom Ammann in this special issue), and in the social democratic LTC system of the Netherlands, they are (still) a marginal phenomenon (Horn et al. in this special issue). Consequently, there is a much longer tradition of research on LIMC arrangements in Germany than in Switzerland and the Netherlands.

In the German context, LIMC arrangements have been examined from different angles, with several studies analysing the working conditions, experiences, life projects and transnational relationships and household strategies of LIMCs (Ignatzi 2014; Karakayali 2010; Kniejska 2016; Satola 2015; Scheiwe & Krawietz 2010). Another set of studies explores the practices of agencies recruiting and placing LIMCs in private households (Krawietz 2014; Rossow & Leiber 2017; Tießler-Marenda 2012), and others discuss the ethical dimensions of this type of working arrangement (Apitzsch & Schmidbauer 2010; Emunds 2016). As yet, relatively little is known about the role of German families in the whole process; for example, how the decision to hire an LIMC is negotiated, how relationships are constructed or how older people in need of LTC perceive their situations. In the Swiss context, different accounts of LIMCs exist (Chau, Pelzelmayer & Schwiter 2018; Schilliger 2014; Pelzelmayer 2016), along with a few studies on families hiring LIMCs (van Holten, Jähnke & Bischofberger 2013), placement agencies (Schwiter, Berndt & Schilling 2014) and migrant care worker organisations (Schilliger 2015). There is a particular shortage of literature on LIMCs in the Netherlands, where only recently scholars started to pay attention to LIMC arrangements (Böcker, Horn & Schweppe 2017; Bruquetas-Callejo 2019; Da Roit & van Bochove 2017).

In comparison to research on LIMC arrangements, rather little academic attention has been devoted so far to the emergence of care facilities in low-income countries which target old people in need of care in wealthier countries. Research shows that a large number of these facilities, especially in Thailand and Eastern European countries, target people from Switzerland and/or Germany but not the Netherlands. In addition, evidence of these facilities can also be observed in Malaysia with a target market in Japan (Toyota & Xiang 2012). Some research also exists on the reasons for the emergence of these facilities, the motives of moving into and the experiences of living in these facilities, the living conditions they provide and the care concepts that emerge (Bender et al. 2017, 2018; Großmann & Schweppe, 2018; Toyota & Xiang 2012).

The four papers in this special issue take up fundamental gaps in research on transnational mobilities of care in old age and address them from different perspectives.

Chau uses a mobility/immobility approach to explore the relationship between the recruitment and placement practices of private brokering agencies and the experiences of circular LIMCs in Switzerland. She shows how placement agencies make high demands on the availability, flexibility and cross-border mobility of LIMCs. For LIMCs, these demands mean being able to leave their environments at short notice and adapt to changing household constellations and different LTC needs almost immediately. As *Chau* reveals, circular LIMCs find themselves in a system requiring nearly constant readiness for cross-border mobility, on the one hand, and immobility upon arrival in the private household, on the other.

How hiring an LIMC affects older people and their homes is dealt with in the article by *van Holten, Kasper* and *Soom Ammann*. These authors argue that hiring an LIMC is often rooted in the family members' wish that older people should stay at home. However, once an LIMC is incorporated into the private household, the home space is transformed by the sudden presence of the unfamiliar. Drawing on data from interviews with family carers, the authors emphasise the efforts made to adapt to the new situation and re-establish familiarity with the altered home space. Different strategies are identified, including solving the puzzle of everyday social interaction and searching for new arrangements. Hence, as shown by this study, the change of the home space can be perceived as too radical for the LIMC arrangement to be maintained.

In a comparative study on LIMC arrangements in Germany and the Netherlands, *Horn, Schweppe, Böcker* and *Bruquetas-Callejo* examine the motivations and justifications of family members hiring an LIMC. Analysing data from interviews with family carers, the authors show how the different LTC systems influence the families' decision-making by providing different LTC infrastructures and incentives to hire an LIMC. German family carers often see no alternative to hiring an LIMC when older people are in need of more intensive LTC. The lack of alternatives provided by the state is at the same time a principal justification used for employing LIMCs irregularly. Similarly, Dutch family carers criticise the lack of affordable 24/7 home-based care services but explain their decision primarily based on their wish for personalised LTC arrangements. In contrast to their German counterparts, they feel uneasier about hiring an LIMC (via a placement agency) and seem to be more compelled to justify their decision to a critical social milieu.

While these three articles focus on the increasing recourse to LIMCs to tackle the care crisis *Bender* and *Schweppe* examine the rather new development that leads in the opposite direction: instead of having care workers "move in", the people in need of care "move out". They turn especially to elder care facilities in Thailand and Poland that target old people in need of care from Germany. Against the backdrop of the main guiding principles of "ageing in place," which guides professional and public orientations for old age care in Germany, considerable criticisms are levelled at these facilities, and their use is viewed with distinct scepticism. Nevertheless, several facilities have succeeded in sustaining substantial demand from Germany over quite a few years. The authors therefore ask what strategies and arguments the facilities use to make themselves a legitimate option for people in Germany and to become established on the German market. Based on two case studies of an old age facility in Thailand and in Poland, *Bender* and *Schweppe* show how they skilfully position themselves as "better" options for residential care even though their strategies vary considerably and result in very different models of old age care. Drawing on neo-institutional organisation theories, the authors show how these strategies are essential for the facilities' emergence as new players in the care market for older people from Germany.

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Producing (im)mobilities in home care for the elderly: the role of home care agencies in Switzerland

By *HUEY SHY CHAU**

Abstract

The Free Movement of Persons Agreement has fostered the emergence of a new market for live-in care in Switzerland. Private care agencies recruit women from the European Union (EU) accession states and place them as live-in carers for the elderly in private households. This paper focusses on how these agencies organise these live-in care arrangements. Drawing on concepts of the politics of mobility, I analyse the production of (im)mobilities through the placement and recruitment practices of care agencies and the power relations that underlie live-in care arrangements. The findings show that live-in care is constituted both by mobilities, exemplified by care workers' circular movements and need to be highly mobile, and by care workers' immobilities once they start working in a household. The care workers' mobility is in turn enabled by the agencies' placement practices and by infrastructures specialised in their movements, which serve as moorings.

Keywords: home care, mobilities, migrant care worker, intermediaries, Switzerland.

**Huey Shy Chau*, Department of Geography, University of Zurich, Switzerland

The Emergence of Home Care Agencies

“It’d gradually gotten worse. At some point, it was too much for me. So I started to do a bit of research online. I just typed in ‘carers from the East’ (*Pflegerinnen aus dem Osten*),” Mr. Schmid explained how he came to use the services of a home care agency. His wife had been diagnosed with Alzheimer’s. He had cared for her for five years before he decided to seek help. This situation is not uncommon in Switzerland, where care has always been considered a predominantly private matter (Schilliger 2014; Schwiter et al. 2018). The majority of adults in need of care live in private households and are mainly cared for privately by their partners (EGB 2010). It was not until Mr. Schmid felt that caring for his wife had become too much of a burden that he decided to try a live-in care arrangement with a migrant carer. “This way, my wife could stay at home and I had some freedom,” he explained.

Care in the global north is increasingly being delegated to women migrating from poorer to wealthier countries (Raghuram 2016). The rise of migrant domestic workers in Asian and North American countries in the 1990s was mainly attributed to the facilitation of local mothers into labour markets (Constable 1997; Ehrenreich & Hochschild 2003; Huang & Yeoh 1996). Since the turn of the century, interest in migrant care work for elderly care seems to have grown. Privately organised live-in care arrangements are increasingly offered as a solution to a care gap in ageing societies. Ever more private households avail care services from a privatised care market. This increasing demand in private home care is also driven by shrinking informal capacities for care in families because of the continuing rise of dual-earning household models, and neoliberal austerity, which have led to shifts from public to private responsibilities for care (Raghuram 2016; Schwiter et al. 2018; Williams 2011).

In Europe, the commercialisation of home care has been accompanied by the emergence of private, for-profit care agencies, who recruit circularly migrating care workers from Eastern European countries and place them in households in the wealthier EU countries (Lutz 2008, 2011; Triandafyllidou & Marchetti 2013). In Germany and Austria, the surge of live-in care for the elderly was sparked by the introduction of the free movement of workers agreement (AFMP) and the Posted Workers Directive, which allows agencies based in recruitment countries to send workers

to provide services on a temporary basis (Bachinger 2009; Krawietz 2014; Österle et al. 2013; Rossow & Leiber 2017). Switzerland does not allow the posting of workers, but it has gradually introduced the AFMP through bilateral agreements with the EU, rather later than EU member countries. The appearance of care agencies and live-in care was first documented in Switzerland in 2009 and mainly in relation to informal arrangements (Schilliger 2009). However, the period since the extension of the AFMP to eight new EU member states in Eastern Europe in 2011 has seen a mushrooming of care agencies officially placing migrant care workers (Schilliger 2014; Truong et al. 2012).

This paper focusses on the role of home care agencies in the commodification of live-in care and sheds light on their recruitment and placement practices. I argue that home care agencies have become important actors in making live-in care accessible in Switzerland and in influencing who performs live-in care and under what conditions. I draw on concepts of the politics of mobility to gauge how migration is enabled and analyse the power relations that underlie live-in care arrangements. Which (im) mobilities are produced through the recruitment and placement practices of home care agencies?

In the following sections, I first provide an overview of the literature on recruiters and brokers in migrant care work. After discussing how the conceptual framework of a politics of mobility enriches my analysis of the organisation of transnational live-in care arrangements, I present the material and methods of this study. The results section explores how care agencies recruit and place carers to private households. In the conclusion, I reflect on the (im)mobilities that constitute live-in care, the underlying power relations and what these mean for future live-in care work.

Migrant Care Work and Agencies

The delegation of care work to women from poorer countries has gained substantial attention in a growing literature on paid domestic and care work since the late 1990s. The discussions relate to Marxist feminist debates on domestic work and labour reproduction in the 1970s (Kofman & Raghuram 2015). Much of the literature has focussed on the globally unevenly gendered and exploitative structures of migrant domestic

work, most prominently captured by the concept of global care chains (Ehrenreich & Hochschild 2003; Hochschild 2000; Parrenas 2000; Yeates 2004, 2012). The global flow of care has been further conceptualised as the care diamond (Raghuram 2012; Razavi 2007) and most recently as care circulation (Baldassar & Merla 2014). The care diamond recognises that the provision of care involves multiple institutions, and care circulation observes that care does not only flow in one direction but is multisited and occurs through asymmetrical reciprocal exchange within transnational families. The literature on global care chains and care circulation includes important insights into the gendered and unequal distribution of care, migration patterns, transnational working and living conditions, and processes within transnational families. Less is known about how migration for live-in care is in fact enabled. This knowledge gap has been referred to as the “black box of migration” (Lindquist, Xiang & Yeoh 2012). Notably, the role of labour migration brokers has not been sufficiently examined.

While many studies have mentioned the role of agencies as a subtopic, relatively few have taken them as a main unit of analysis in migrant care work. Some scholars have focussed on the role of agencies in enabling employers to find carers and examined how agencies gain access to care workers. In a study in Los Angeles, Hondagneu-Sotelo showed that the agencies depict themselves as indispensable matchmakers to employers, who seek “idiosyncratic traits, such as personal compatibility” (Hondagneu-Sotelo 1997: 5). Focussing on a subsystem of local recruiters and informal intermediaries in Indonesia, Lindquist (2010, 2012) showed that agencies can play a key role in creating trust between would-be migrants and employers. Other studies stress the important role agencies play in facilitating complicated bureaucratic procedures to enable migration and in elevating standards for migrants (Goh et al. 2017; Kern & Müller-Böker 2015). In Europe, scholars have noted that care agencies often work with recruitment agencies in the recruitment countries to access care workers (Bachinger 2009; Krawietz 2014; Rossow & Leiber 2017). Another strategy is to encourage informal networks of carers to recommend other care workers to the agency (Schilliger 2014). Elrick and Lewandowska (2008) showed that many agents in Poland were deeply embedded in migrant networks; these authors argue that they play a significant role in continuing migration flows.

Another strand of literature focusses on the production of stereotypes based on gender, nationalities, and other markers of identification fostered by employers and agencies. The stereotypes have been discussed as ethnicisation (Abrantes 2014; Bachinger 2009; Krawietz 2014; Schwiter et al. 2014) and racialisation (Bakan & Stasiulis 1995; Guevarra 2010; Hondagneu-Sotelo 2000; Liang 2011). Moreover, studies have shown that recruiters actively create divisions and hierarchies between workers. Hondagneu-Sotelo (2000) demonstrates that women from English-speaking countries are placed in the United States as nannies, whereas women from Latin American countries are matched to households for domestic work. Similarly, Loveband (2004: 336) shows that Taiwanese agencies distinguish between domestic workers from Indonesia and the Philippines in ways that lead to Indonesian women often “doing the dirtier and more demanding jobs.” Hence, the way that brokers promote essentialist stereotypes channels workers into specific sectors of the labour force.

The traits that agencies seek and promote in-care workers vary according to context. In their study on Sri Lankan domestic workers in the Middle East, Eelens and Speckmann (1990) observe that agents preferred to recruit women from rural places, as they are deemed to be more accustomed to hard work. Focussing on migrant carers in Taiwan, Liang (2011) finds that agencies look for naïve, childlike, innocent characteristics in applicants, who can be transformed into submissive and obedient workers by training centres. In Europe, scholars have found a very different idealised picture of live-in migrant care workers. Recruitment agencies portray care workers as devoted, family-oriented, mature women from Eastern European countries with traditional values and the skills to adapt to their places of work (Bachinger 2009; Krawietz 2014; Schilliger 2014).

In sum, studies have shed light on the subjectification of care workers, the creation of local and global divisions between workers, and the role of agencies as gatekeepers into labour markets. Much of this research, however, presumes the existence of such labour markets and emphasises the power of agencies as gatekeepers. Relatively little is known about how home care agencies organise transnational care arrangements at a mundane level. Moreover, little is known about the role of home care agencies

as key drivers in the commodification of care from informal live-in care arrangements to the establishment of a formal market. This paper relates to these discussions by focussing on the practices, discourses, and infrastructures that actually enable movement in live-in care.

The Politics of Mobility

To analyse the organisation of live-in care arrangements, I draw on conceptual debates known as the “new mobilities paradigm” (Cresswell 2006; Sheller & Urry 2006; Urry 2007). The “mobility turn” arose in response to sedentarist theories in the social sciences; these theories consider a sedentary form of life tied to bounded places to be the norm (Sheller & Urry 2006). Instead of understanding stability and bounded places as basic units in social research, mobilities scholars focus on the movement of people and things. Hence, the mobility turn marks a shift within the social sciences from a “metaphysics of fixity to a metaphysics of flow” (Cresswell 2006: 25). However, unlike debates focussing on deterritorialisation processes, which celebrate mobility and liquidity in a global world and so tend to neglect the importance of space and place in social sciences, the new paradigm does not abandon the notion of fixity altogether (Sheller & Urry 2006). Instead, fixity and movement form a dialectic relationship that underpins social life. Mobilities are enabled and supported by immobilities, or what Urry (2003) calls “moorings.” Correspondingly, mobilities scholars often examine mobilities and movement in relation to notions of fixity, immobility, and moorings; they pay attention both to social and spatial relations and to infrastructures of mobilities, and hence foreground the fact that movement is never without context.

Recently, scholars have also called attention to the “larger apparatus of power in which (these) relations of mobility are situated and governed” (Sheller 2016: 17) and outlined approaches to a politics of mobility (Adey 2006; Cresswell 2010). In politics, Cresswell (2010: 21) includes the “social relations that involve the production and distribution of power.” Accordingly, a politics of mobility addresses the question of how mobilities are produced as well as how they create social relations. He sees mobility as a “resource that is differentially accessed” and distributed, and he proposes thinking about who moves to where and how mobility

is presented and embodied (Cresswell 2010: 21). Moreover, he considers six aspects of movement: why, how fast, in what rhythm, what route, how does it feel, and when and how does it stop (Cresswell 2010).

The focus on mobilities in care work has increasingly gained attention, as the number of studies in home care, some more loosely related to the new mobilities paradigm, shows (Baldassar & Merla 2014; Cuban 2013; Cuban & Fowler 2012; Huang et al. 2012; Schwiter et al. 2014). The questions of power relations and mobility, however, are nothing new; they have a long tradition in feminist political economy approaches to social reproduction and in feminist geographers' research into gender and work long before the mobility turn (Cox 2006; Hanson & Pratt 1995; Mahler & Pessar 2001; Massey 1993). Scholars have recently called for a framework that more explicitly unites the mobilities concept with research on movement between places in relation to gender, work and power relations (Cresswell et al. 2016; Dorow & Mandizadza 2018; Dorow, Roseman & Cresswell 2017; Roseman et al. 2015). Termed employment-related geographical mobility, this concept calls for "looking at the way in which forms of mobility are either enabled by, or impeded by, other forms of (im) mobility" across different scales and for understanding the connections between them (Cresswell et al. 2016: 1792).

Using the new mobilities paradigm, this paper enquires into the (im) mobilities that constitute live-in care for the elderly. I focus on the role of care agencies in the production of (im)mobilities through their recruitment and placement practices. I consider who are selected as carers, in what rhythm they travel back and forth between their homes and places of work, what routes and forms of transport they take, how fast they are employed and their different starting points. I use these insights to shed light on the politics of mobility in the organisation of live-in care arrangements.

Data and Methods

The research presented here was conducted in line with ethical guidelines in qualitative and feminist research ethics (Denzin & Lincoln 2011; Hesse-Biber 2012). The empirical material is based on in-depth interviews with 20 representatives of 13 care agencies in Switzerland, Hungary, and

Slovakia and with 13 carers from Poland, Hungary, and Slovakia between 2013 and 2016. The sample includes a wide range of agencies, from one-person businesses with around 10 care recipients to well-developed agencies with more than 100 care recipients. The sample also covers a range of price segments from 2000 CHF (ca. 1620 Euros)¹ per month up to more than 12,000 CHF (ca. 9720 Euros) per month. I also conducted interviews with a care recipient, a trade unionist, and a representative of the State Secretariat for Economic Affairs to gain information on the legal context and development of placement practices. My material consists of recorded and transcribed interview data, informal conversations, field notes, and documents related to the marketing and working conditions of live-in care work². The interviews were conducted in German (21), Hungarian (9), and Slovakian (6). The non-German interviews were translated into English by field collaborators. Of the 36 interviews, 20 were fully transcribed verbatim, and seven were partially transcribed. I use fictive names for all interviewees, and I anonymised them so that links cannot be traced between them and specific business practices.

I used grounded theory methods according to Charmaz (2014) to analyse the material. Drawing on Strauss and Corbin (1990), Charmaz proposes two main coding phases, initial and focussed coding, before writing up the results. Initial coding moves quickly through a large amount of data from selected interviews and stays close to the data. In contrast, the purpose of focussed coding is to first establish analytic directions by grouping codes into categories, which are then applied to the rest of the material (Charmaz 2014). Accordingly, I applied initial coding to full transcripts of eight interviews with care agencies, a group conversation with

¹ CHF was equivalent to around 0.81 EUR in May 2014. Exchange rates of 15th May 2014 calculated according to the online currency converter XE ('XE Currency Converter' 2017).

² During fieldwork, I visited a care agency in Slovakia, travelled by car with a care agent and care workers from Slovakia to Switzerland, and accompanied carers when they arrived at the households to start their employments. I visited an agency and a group of care workers in their home village in Hungary. I visited another carer at her place of work in Switzerland and in her home village in Hungary; there, she took me to a café where a group of nine care workers met for coffee and discussed the organisation of live-in care work. I also intermittently visited the group Respekt, a group of care workers that advocates for improved working conditions in live-in care. While out in the field, I took notes of my observations and wrote down aspects I had learnt in these situations.

carers in Hungary, and three interviews with carers using the MaxQda analysis program. Subsequently, I grouped the codes into categories and used these to sift through the rest of the material. While doing so, I added new codes to categories, and renamed and merged codes into subcategories. The subchapters in this paper correspond to key categories relevant to the recruitment and placement of care workers. I kept the coding process in two separate projects: one with care agencies and one with carers. The material in this paper is partially linked by ideas on mobile ethnography (Büscher & Urry 2009; Faist 2012). The concept addresses the spatial movement of people through direct observation of associated social practices. Although it had not been my initial intention, my material turned out to provide a fruitful insight into practices that result in mobility and immobility in live-in care work. For this paper, I chose particular moments and quotations that I consider relevant for the reader to understand how live-in care work is organised.

Mobilities that constitute live-in care arrangements

Live-in Care as All-Inclusive Deals and Win-Win Situations

Many agencies offer package deals for differing levels of care dependency. Designed as all-inclusive offers, the packages include matching with carers, the organisation of their arrival and departure, administration such as wage accounting, registration with social insurance offices, taxes and applications for residence permits. Once care agents have identified possible carers for a household, they often forward a selection to the care recipients and their family members. Moreover, care agencies offer to replace carers in case the relationship between the elderly care recipients and live-in carers do not develop as expected. What is also remarkable is how fast a care arrangement can be organised: “Uncomplicated and fast,” one of the care agencies advertises, “it takes a maximum of 60 minutes’ effort. You can welcome a carer at your door after 6–10 days.”

With the development of a broad landscape of agencies offering all-inclusive home care deals, and with costs starting as low as CHF 1600 (ca. 1300 EUR), it has become much easier for the elderly and their families to access live-in care. Not only is it possible to gather information and compare offers on agencies’ websites but also to book their services online.

In this sense, home care agencies are a crucial entry point for the elderly and their family members to a live-in care arrangement. For example, Mr. Schmid would not have hired a live-in carer on his own: "I'd never do that. Firstly, because of the permits. (...) Then there's social insurance, old age insurance, unemployment insurance, then the benefit plan. This is all really complicated." For him, the fact that he was not responsible for organisational work was decisive.

Some of the care agencies, especially those in the low-cost segment, market their offers as a win-win solution:

For many Swiss it is not possible because of financial reasons to afford 24-hour care from local service providers. (...) The carers (...) are in a similarly difficult situation. The care employment offers them the possibility to work in the profession they were trained in and earn a much higher salary than in their home country. Hence, after their stay in Switzerland - where they can get to know a new culture besides the work and improve language skills - they go home with a good financial situation. Therefore, both parties benefit. (Website of a care agency, 2015. Translated from German by author.)

This is not surprising, as this marketing strategy aligns with the win-win logic of circular migration policies (Castles 2006; Wickramasekara 2011). Therefore, the fact that care workers have to travel far is concealed in all-inclusive packages, and carers' movements and mobility are represented as part of a win-win situation.

Travelling Back and Forth and Repeated Short-Term Assignments

The agencies organise various forms of working arrangement, sometimes according to the care-recipients' preferences. Some arrangements consist of two carers who rotate every few weeks in the same household and who go back and forth between Switzerland and their home country. For instance, one of the larger agencies in the high-price segment employs carers for two weeks without a free day and rotates them every two weeks. Other agencies' main operating model replaces a carer in a household after three months or less, so that an elderly person is cared for by at least four different carers during a year. The reason for this is connected to migration regulations. Within the AFMP act, EU nationals working less than three months in Switzerland only have to register their stay online. Workers staying longer have to apply for a residence permit and pay health insurance.

With the model of constant placements of new care workers, agencies can offer live-in care for lower costs. Other agencies organise a mix between regular rotation and short-term placements. For example, the agency that Mr. Schmid had engaged typically organises repeated two-month assignments with the same carer and one-month reliefs in between, with the person on relief changing every time. For care workers who are frequently placed into new households, this can be tiring. Having to get acquainted with “a new environment, a new situation, a new disease, a new person every time is very exhausting,” as Marina, a live-in carer from Hungary, stressed. All of these work arrangements are legally permitted, as long as the agencies are based in Switzerland. However, the sample also includes two agencies that were based in Slovakia and Hungary; these illegally employed the model of constant placement of new care workers, sometimes without registering the care workers with the local authorities.

The agencies organise both the match with a household and the care workers’ trips from door to door. Some require carers to travel with them, while others let them travel on their own if they cover additional costs themselves. In my sample, only one of the agencies in the upper price segment had organised the care workers’ trips by booking flights. All the others collaborated with transport businesses in the recruitment countries. The use of private transport businesses can facilitate the organisation of the journey as well as the journey itself. It can even be less expensive than public transport. However, the bus journeys are often long and tiring and, depending on the agency and transport business, more or less uncomfortable. The care workers I met in the café in Hungary were very aware of the advantages and disadvantages of traveling with an agency. “It is a great help for those who use the service of an agency. But this help has its costs. You are very constrained,” one of them explained. If care workers have to travel with an agency, they may incur inconveniences such as longer traveling times, reduced comfort and restricted luggage space. “And they go around the towns. They stop in between. They don’t go a direct way,” another care worker says in the group conversation. “Imagine, they picked me up at 4 p.m. (...) [and then in the] morning at 4 a.m. I arrived. They took me all over [the place],” she recalled her experience.

If care workers have to cover the costs themselves, it can play a role in their choice of transport. “Some families pay for the travel, some don’t,

so in this case, you would just look for the cheapest option,” one of the care workers explained. Kata, a care worker from Hungary, takes an 11-hour bus ride to reach her place of work. In contrast, Anna, also a care worker from Hungary, takes a flight from Budapest to Zurich. Anna is paid a daily rate of CHF 120 (ca. EUR 97) salary and an additional CHF 600 (ca. EUR 486) per month that her employer agreed to contribute for travel costs, so she is willing to spend higher costs for more comfortable transport than Kata, whose salary is much lower at 50 Euros per day. Therefore, care workers may experience very different journeys in terms of duration, costs and comfort, depending on their financial means and agencies’ travel organisation. The more care recipients are ready to pay for transport, the more comfortably they can travel without having to pay extra out of their own pockets.

Building Pools of Care Workers

Live-in care services are characterised by the interchangeability of care workers, who can be placed relatively fast. This disposability and flexibility constitute an integral part of care agencies’ business model, so how do they achieve this? Many of the agencies interviewed build pools of care workers. What is striking is the size of some of the pools, especially in relation to the numbers of care recipients. For example, Daniel’s placement agency had built a pool of around 500–600 potential care workers. However, only 110–120 were placed for 100 care recipients at any time. He explained:

(...) you have to have a large pool to be able to react to all demands. And then, as I said, not every customer is the same, I don’t want to standardise anyone, so we need as many different carers as possible that can be matched to the individual clients.

His agency was able to organise a care arrangement as fast as within 72 hours. “Flexibility is at the heart of this business,” he states, “without flexibility, the business model does not work.” Hence, Daniel legitimises the need for the large pool of carers by prioritising the need to satisfy demand.

Employment agency owner Pascal had built a pool of 32 care workers. He had placed carers with five care recipients. Although care workers can only work up to three months per year with him, he does not consider

how they are able to reconcile such placements with their jobs and activities at home to secure another income than working with his agency:

I have a lot now who don't work with me, who work in Germany. I don't care who they work with there. But I don't want, if I call, and I need them, that they say they are in Germany. Then I say, you have to decide now where you want to work, with me or in Germany.

Hence, Pascal delegates the responsibility for organising a stable income to the individual care workers. Another agency had built a pool of 150 care workers. The agency's recruiter, Andrea, explained that often it was not up to her to decide when a placement began, as many of their clients would be released from hospital and need 24-hour care at home right away:

So we always say, the more flexible you are, the better for you. If they tell me that they're only able to start next week, but in the meantime a placement comes up, then it's too bad for them. Then we ask the next person. If they tell me they're sitting on suitcases that are already packed, able to take a plane the next morning, then it's better for them.

Similarly to Pascal, Andrea makes clear that being flexible would be in the carers' own interest if they want to increase their chances of a placement. Consequently, the agencies create conditions in which carers have to be mobile and flexible in order to be employed.

Subjectivising Care Workers as Mature, Warm-Hearted, Highly Motivated Women from Eastern Germany and Eastern Europe

Recruitment involves three key points that are relevant in understanding the (im)mobilities required for live-in care arrangements. The first point concerns where carers are recruited and the ascription of "warm-hearted" characteristics to these places. Live-in care arrangements are clearly not meant for local carers, as care agent Livio puts it:

Imagine, a woman comes here as a live-in carer, starts to save money, and starts to pay rent for her own apartment. And then her boyfriend joins her (...), they live together. Maybe they have a couple of kids. Now, (...) is this woman supposed to sleep and live in the care recipient's house? Forget it! (...) This model is not suitable for [permanent] residents [in Switzerland].

Hence, live-in care work is supposedly irreconcilable with having one's own family in spatial proximity. The care workers are not supposed to

centre their lives in Switzerland, but in what is conceived as “their own home” in the recruitment countries. Correspondingly, the salary that live-in carers receive is usually not sufficient to live in Switzerland. As a consequence, and because live-in carers usually have to be on call around the clock, they lack the chance to build social relations outside the care arrangement (Chau et al. 2018). Live-in carers are effectively immobilised in the households by the specific characteristics of 24-hour care work.

In order to legitimise the recruitment of non-local carers, some of the agents expressed essentialist claims about the traits of carers from specific places (Pelzelmayer 2016). Care agent Pascal, who only recruits from Hungary, claims that “people from the eastern countries have a different moral concept than we do. (...) The Hungarians, they’re the closest to us as far as ethics and values are concerned.” Dominik, another care agent, legitimises the recruitment more generally from Eastern European countries by comparing it with the recruitment of another agency, the only one in the sample that recruits from eastern Germany and not from the EU-8 countries: “For us Swiss people, High German is a little bit arrogant. And the Germans are a little bit more quick-tempered, faster, and arrogant. They are not as warm-hearted (*herzlich*) as people in the Slavic parts of Eastern Europe.” Therefore, Dominik ascribes a supposedly warm-hearted character to people from places in Eastern Europe, to the extent that he would not recruit carers from other countries. These recruitment practices lead to uneven access to live-in care work. By actively associating people from Eastern Europe with a character that is warm-hearted and has a better work ethic towards the elderly than carers from Switzerland or other places, they reproduce an otherness that marks care workers from Eastern Europe as supposedly more suitable for elderly care.

The second key point is related to the care agents’ construction of carers as selfless people with a heart for the elderly. Many of the agents interviewed tend to prioritise a particular attitude over relevant skills or experience in the health sector. “Anybody can do it. No qualifications are needed. It’s just housework,” said care agent Pascal. However, he emphasised the importance of the applicants’ motivations to selection: “If someone asks from the start how much can I earn, how much free time do I have, then I say, well, okay, I won’t call you anymore.” Care agent Daniel stressed “warm-heartedness (*Herzlichkeit*) and the will to help someone”

as important criteria. He argued that lateral entrants were sometimes even more suited for live-in care than professional care workers. Another agency even recruits retirees as care workers. When I asked Andrea about selection criteria, she answered:

The helper syndrome, the heart in the right place. That is essential. (...) If one's willing to work but maybe not trained professionally, that doesn't automatically mean rejection. Because it's empathy that one must have, willingness and kindness (...). Why does she want to do this work? Is it about money? Or, are they retirees who really want to be active and help?

The quotations imply that professional health care skills and experience are secondary to the motivation of potential carers and that the motivation should not derive from financial interest in a job but rather from some kind of inner urge to help the elderly. The binary classification of applicants into whether they were motivated "to help" or primarily interested in money exacerbates the underlying problems of care work as undervalued employment, which ultimately benefit employers and care agencies (McDowell 2009). The definition of care work as not requiring professional skills can be understood as a legitimisation of the low salaries; according to Akalin (2015: 72), it "is an intervention on the part of the employers pursued precisely to increase yields from their workers in every sense." Moreover, the image of a warm-hearted, kind, and selfless person seems to envisage the carers as a family member rather than an employee. In this context, Schilliger (2014) has noted that the portrayal of carers as family members serves to legitimise the blurring of boundaries between working and free time and to justify longer working hours.

A third key finding concerns the role of the recruiters in understanding care work as a gendered activity. Their recruitment practices can be located within existing conceptions of gender norms. According to Bock and Duden (1976), domestic work was transformed into a "labour of love" and constructed as the natural domain of women in the capitalist development of industrial societies. The delegation of care work to another woman is hence accepted to a large extent, because it stays in the logic of "doing gender" (Lutz 2005). Correspondingly, many recruiters explain that care recipients and their family members would prefer women as carers. Yvonne, managing director of an agency, states: "Most elderly women won't accept a man. That's generally a problem in health care."

Why women are considered more suitable for live-in care, however, was only vaguely answered. Care agent Dominik for example, said: “[they are] just more warm-hearted (*herzlicher*), the mother instinct, I don’t know what kind of thinking, I mean, if you look at old age homes, there too it’s women carers. That’s why.”

What is striking is that many care agents prefer to recruit women of a certain age. Krawietz (2014) finds in her study on the transnational organisation of live-in care in Germany that higher age is portrayed as a competence that would specifically qualify for live-in care work. “Most of our women are between 45 and 60. We don’t have women under 30. Well, we had bad experiences with some. And if they’ve got young kids, then they’re also less worth thinking about,” said Dominik. Apart from the consideration that “they’re not separated from their children for a long time,” another reason for employers to avoid women with children is that care workers are entitled to family allowances, which employers have to pay. This would make live-in care more expensive. Moreover, some of the care agents implied that older women prefer to lead a quiet life at home, while young women would want to go out and have a social life. I was also told that older women usually have a family back home and so would not attempt to settle permanently in Switzerland. Care agent Livio even used age to justify difficult working conditions, implying that older women would supposedly be able to better handle rough working conditions because of their life experience: “Don’t imagine they’re young girls. (...) These are mature 50-year-old women, they’ve raised children, maybe gone through a second divorce in Poland (...) They come from very tough private circumstances.” In this sense, care agencies reproduce the discourse of care work as a gendered domain by predominantly selecting women, and in our case, women of a certain age. Thus, women with young children and men are “structured out of mobile reproductive work” (Dorow & Mandizadza 2018: 8).

To conclude, recruiters select care workers by gender, recruitment locations, age, family situations and more elusive criteria such as the motivation and mentality of applicants. These recruitment practices characterise live-in carers in Switzerland as older, warm-hearted, highly motivated women from eastern Germany and Eastern Europe. By engaging in spatially selective recruitment of workers from Eastern Europe, and by linking the places to specific traits supposedly required for care work,

care agencies contribute to the creation of stereotypes and discriminate against would-be care workers from other places. Consequently, their recruitment practices actively contribute to the construction of a gendered migration channel from Eastern European countries to the Swiss live-in care labour market.

Despite a coherent portrayal of who is deemed adequate to perform live-in care work, the results show that there is no clearly defined job profile for live-in carers. Instead, the key criteria in the selection of carers depend on the business models and marketing strategies of the various care agencies. Within the same labour market, the agency that Andrea works for only recruits from eastern Germany, underlining the importance of language skills, while Dominik only recruits from Slovakia and Poland because of the supposedly “warm-hearted character” of a care worker from these places and Pascal only recruits from Hungary because of the supposedly similar work ethics of Hungarian carers and Swiss carers. Another differentiation in recruitment can be observed in relation to the experience of the agents in the health care sector. Care agents who stress that anybody is able to do care work such as Pascal and Dominik, neither of whom have experience in the health care sector, seem to look for “not too dominant” and “devoted” carers. In contrast, care agents that have strong backgrounds in care work emphasise that care work is demanding and hard work and requires carers to have strong communication skills and the ability to stand up for themselves. Thus, the weightings of selection criteria do not follow a uniform logic across the care agencies, and selection mirrors divergent conceptions of what qualifications a care worker should have.

Differential Mobilities of Care Workers

How fast would-be care workers find themselves on their way to a placement in Switzerland depends not only on the recruitment practices but also on the backgrounds that constitute live-in carers’ starting points and their own perception of whether they are ready for the job. Sara, a care worker from Slovakia, had only applied around 10 days prior to her first placement. She had lived in Switzerland before. After graduating in psychology in Slovakia, she had trained as a care assistant in Switzerland, where she learnt German. She had been temporarily unemployed when

she came across a job post on Facebook. "I called and she [the recruiter] said, send your CV and we'll see. Everything went very fast. Within two days she called me to say, yes, so we have a man, he needs help. (...) And so I said, yes okay, I'll try this," Sara recalled. She was surprised that she got the job so fast. Ilona's case, a care worker from Hungary, is entirely different. Having worked at the post office in the village since she was 18 years old, she had been toying with the idea of going abroad as a carer for a long time. "The children have grown up, see, and you'd like to fly off a bit and you'd like to do something else" she said. In order to prepare for her first placement, she started to attend German classes in the village, which was organised by the agency that recruited her. While many of the care workers who registered with the agency later than Ilona had already gone to placements, Ilona had not by the time we spoke. Why are some care workers readier than others to venture into live-in care work?

By comparing her own background with other care workers, Ilona was very much aware that the women in her region leave from highly diverse starting positions. Her situation presented four salient aspects. Firstly, she felt that her German skills were not as good as other care workers yet. Her cousin, for example, already knew German. Thus, "her language knowledge was very suitable," when the agency first came to their village, she explained. Moreover, Ilona mentioned a woman that had only recently joined the agency but had long-term experience as a care worker in private placements. That woman had been commuting between her assignments in Germany and in Switzerland for years. In contrast, Ilona did not have any experience in live-in care work. Secondly, Ilona's plan to work abroad was not only to seek adventure; she also took financial issues into account. However, she was not in immediate financial distress, as she had been employed in a stable job for many years. In contrast to her cousin, who in Ilona's words was "more forced into it financially," she was not dependent on working as a live-in carer to secure her income but considered it as an option to improve her financial situation. Thirdly, it seems to be easier for those who have fewer ties and, in her words, "constraints here at home," such as family. "She [the cousin] doesn't have a husband, she's single. And she can arrange to go next to her job [in Hungary]," Ilona explained. In contrast, Ilona has three children and a husband from whom she did not want to be away when the children were younger. Now that her two older sons were attending university, her idea to work as

live-in carer became more feasible. The only downside Ilona saw in live-in care work was that the agency only enables care workers to work three one-month assignments per year, leaving the care workers without any income for the rest of the year. This was not compatible with her job at the post office, and she would have to resign from her job. Therefore, fourthly, going on a home care placement is decided by whether would-be care workers are able to reconcile placements abroad with their own activities and jobs at home as well as by the length and stability of the care work arrangement itself. The decision to go on placement can thus be seen to depend on these four aspects: language skills and care work experience, financial situations, family situations and compatibility of placements with employment situations at home.

The four aspects form a useful basis for a comparison with Sara's starting point. Sara had a degree in psychology, was trained as a care assistant and spoke fluent Swiss and German when she applied for her job as a live-in carer. The placement was temporary, for just two months. Consequently, Sara, who was not married, did not have children and was unemployed at the time, felt able to more or less spontaneously venture on her first placement. Hence, Sara has higher capacities than Ilona for mobility and for venturing into live-in care. In comparison to her cousin and to Sara, Ilona's financial stability, employment in the village and ties to her family can be understood as immobilities that compromise her capacities for mobility. This shows that care workers may experience difficulty in reconciling live-in care work with their own activities and jobs at home. This is especially so when working with agencies that place care workers in short assignments and do not guarantee a stable income. Hence, the working arrangements that care agencies offer play a role in care workers' access to live-in care work, as does whether agents take the stability of care workers' incomes into consideration.

Conclusion

Home care agencies offering all-inclusive home care play a key role in shaping live-in care by managing the spatial and temporal aspects of care workers' geographical mobility: that is, the (im)mobilities required to enable a live-in care arrangement. As I have shown, care agencies produce a particular system of mobilities, and this shapes live-in care

migration as a form of movement characterised by repeated short-term and “just-in-time” assignments and frequent changes of households. The care agencies require a relatively high capacity for mobility from the care workers: they should be able to start a job at short notice and travel back and forth between their own homes and their workplaces. The greater the capacity for mobility that prospective care workers possess, such as being able to leave at short notice and not having to take care of small children at home, the more access to live-in care work they have and the more likely they are to be recruited and placed in a household. Hence, caring for care recipients in their own homes is only made feasible by care workers’ readiness to be mobile. Moreover, care agencies offer all-inclusive home care packages with salaries that, while affordable to care recipients and their families, are not enough for care workers to live in Switzerland. This produces a degree of isolation for the carers at their workplaces; in other words, it immobilises them in the households.

I also showed that care workers’ comfort in their journeys depends not only on their own financial means and access to various transport services but also on whether care recipients are willing to cover their travel costs and on care agents’ organisation of journeys. What becomes apparent is the asymmetry in the triangular relationship between care recipients, care agencies and care workers. The main people making decisions in the matching process are usually the care agents and the care recipients. The care workers have relatively little control in comparison; after being selected, they are usually only left with the choice whether to accept or decline whatever employment is offered to them. In cases where carers are asked to begin a placement as fast as possible, those that are flexible enough to accept the conditions and start work the next day have an advantage over those who need time to organise their journey. Care agents try to increase a flexible disposition by creating pools of workers. Speed matters in the matching process. The higher the readiness of care workers, the faster they can be placed, the more care recipients and care agents benefit. Hence, those that are more flexible can actively weaken the opportunities of care workers that are less flexible. As shown above, the latter are usually those with families at home in need of care. Consequently, it is not just other care workers that can be affected by this requirement for readiness but also the families of the carers themselves, who have to support this flexibility and organise their everyday

lives accordingly. Practices such as online video chatting to maintain relationships with family, the sharing of experiences through Facebook groups and even the provision of food to the left-behind elderly in the carers' home villages are important moorings for care workers' capacity for mobility.

In sum, live-in care arrangements are constituted by a set of (im)mobilities embodied by care workers' capacities for mobility, their repeated movements between their homes and places of work, and their isolation once they have started work in private households. The mobility of care recipients' family members, or "freedom" in Mr. Schmid's words, is anchored in care workers' readiness to be mobile and in their immobility once they arrive at the households. However, care workers' immobility in a household should not be seen as an absolute mooring but as a relative immobility. It is fluid in the sense that care workers do not stay in a household forever. On the contrary, they leave the household after a period of between two weeks or three months, and they move back and forth between Swiss households and their own homes in the recruitment countries. The carers' geographical mobility is in turn enabled by the care agencies' placement practices and growing infrastructures specialised in their movements, such as transport businesses, which serve as moorings.

This specific form of movement for live-in care work is not a coincidence, but the result of an interplay between the profit-maximising business practices of agencies and migration and labour regulations. The practices that enable live-in care arrangements through migrant workers are linked to societal negotiations of how to understand new family relations and responsibilities in care work. Care agencies contribute to the production of an unequal division of care labour in the transnational context. However, the development of private for-profit live-in care agencies has not gone unnoticed. On the contrary, it has moved to the forefront of mass media and public discussions. Trade unions, migrant worker organisations, departments of equalities in various cities and politicians have approached this development as an opportunity to negotiate carers' working conditions (Chau et al. 2018; Schilliger 2015).

Live-in care of the elderly by women migrant care workers in Switzerland is based on two main inequalities: an unequal distribution of care work between men and women and unequal working and living

conditions between migrant workers and locals. It is a short-term solution that reinforces gender and socio-economic inequalities. A solution for society as a whole to care of the elderly is only sustainable if it addresses these inequalities in the long run rather than merely the “care crisis” (Schilliger 2014). This means that care work has to be more highly valued. It also means that working conditions and salaries have to be improved so that workers caring for the elderly are able to secure an income that allows them to live in Switzerland. More precisely, care work should enable carers to work shifts and hours comparable to those of local carers in the health sector, to live away from the care recipients and to enable time and capacity for carers to also care for themselves and their own family members.

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Corresponding Author

Huey Shy Chau, Department of Geography, University of Zurich, Winterthurerstrasse 190, 8057 Zurich, Switzerland. Email: hueyshy.chau@geo.uzh.ch

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Fragile familiarity in transnational home care arrangements for older people

By *KARIN VAN HOLTEN*¹, *HEIDI KASPAR*¹ & *EVA SOOM-AMMANN*²

Abstract

This paper examines the notion of familiarity in live-in elder care settings and how it is challenged, changed, and reestablished. Live-in care is a strategy to prevent disruptions and preserve familiarity in enabling older persons in need of extensive care to stay at home – and thus, to enable ageing in place. This paper problematizes this strategy based on interviews with family caregivers who engaged a migrant live-in care worker in Switzerland. The key argument is that live-in care arrangements constitute an all-embracing form of inserting formal, paid-for care service delivery into the informal, private, intimate space of home. The live-in care arrangement not only challenges the familiarity of the home space, but also seems to ask for strategies of adaptation to familiarize the unfamiliar. Therefore, the introduction of live-in care is consequential for all involved parties and requires largely underestimated efforts to adapt to the new home space.

Keywords: care migration, familiarity, home, home care, live-in care, long-term care, old-age care, transnational care.

¹*Karin van Holten & Heidi Kaspar*, Department of Health Sciences, Careum School of Health, Kalaidos University of Applied Sciences, Zurich, Switzerland

²*Eva Soom-Ammann*, Department of Health Professions, Bern University of Applied Sciences, Bern, Switzerland

Introduction

Ageing is about change and adaptation. While ageing, bodies, and capacities are subject to change, physical and cognitive limitations emerge and create new care needs and requirements that foster well-being. Ageing prompts reconsidering, negotiating, and altering established daily routines and preferences. This may lead to material transformations of the home, such as added handles in the shower, removed carpets on the floor or installed high-tech devices such as sensor-integrated floors with automated alarm systems (Doh et al. 2016).

Caring for the older people is about adaptation, too. Social ties and networks are likely to alter with increasing dependency on support (Allan & Crow 2001; Chambers et al. 2009; Silverstein & Giarrusso 2010). Not only are changing age-related needs and dependencies affecting preexistent social relations, but they also introduce new actors to social networks and to the home: unfamiliar persons providing health and/or social care may enter the domestic space and, hence, challenge the specific quality of home considered as a place of privacy and intimacy (see, e.g. Angus et al. 2005; Dyck et al. 2005; Haak et al. 2007).

In a setting of ambulant caregiving, the potential challenge to privacy, intimacy, and familiarity of the home space is an episode of exception. Here, professional healthcare providers enter the home space on a timely restricted basis. But when live-in caregivers move in to provide around-the-clock home care, the exception stretches in time and pervades the everyday, posing a fundamental challenge to the home space. This starkly contrasts with the intentions of opting for live-in care arrangements, namely, to prevent disruptions and promote continuity (van Holten et al. 2013). Family caregivers who arranged live-in care equate preserving familiarity with remaining at home (*ibid.*). Such an equation presumes the home space as an immutable entity that once it has been made familiar remains familiar.

In this paper, we examine the notion of familiarity in live-in care settings for older people and how it is challenged, changed, and reestablished in the course of altering home care settings. In doing so, the paper contributes to the body of work that reflects on care in the home space. Research in this field focuses on consequences of professional health and social care in the home (e.g. Angus et al. 2005; Dyck et al. 2005;

Stephoe et al. 2015), or on different kinds of care, that is, formal and informal care, including reflections on the specific role of family caregivers (e.g. Milligan 2000, 2005; Milligan & Wiles 2010; Twigg 2001). From both perspectives, the literature illustrates that the home care setting is characterized by blurring boundaries between formal and informal, paid and unpaid care on the one side and between health and social care on the other side. Live-in care in Switzerland (as in other countries, for example, Germany, Austria, and Italy) is provided by a paid-for care worker who usually migrates from abroad for this job, stays in the home for some weeks or months, taking turns with colleagues (i.e. circular migration patterns). Live-in care arrangements are also referred to as around-the-clock care or 24-hour care, indicating that comprehensive care needs are met in private households by a migrant care worker at place. Furthermore, this term already implies problematic dimensions inherent in live-in care arrangements, such as the dissolution of boundaries between work and leisure time and the tendency toward exploitative living and working conditions of migrant care workers. To sum up, one could say, this home care arrangement is a strategy to enable ageing in place that, while being contested, is gaining popularity (for an overview, see Anderson 2012; Lutz 2011; Metz-Göckel et al. 2008).

Based on a secondary analysis of interviews with family caregivers in Switzerland who had arranged a migrant live-in care worker, we problematize the live-in care arrangement. We show how discursive negotiations of such arrangements by family caregivers illustrate the fragility of familiarity and the contestation of home as a familiar place in these settings. The key argument is that the live-in care arrangement constitutes an extreme form of inserting paid-for care service delivery into the private, intimate space of home. The introduction of migrant live-in caregivers into home care settings not only challenges the familiarity of the home space, but also seems to ask for strategies of adaptation to familiarize the unfamiliar, thus to redefine the meaning of home or to reestablish home by integrating up to now unfamiliar elements or persons into the home space. Therefore, the introduction of live-in care is consequential for all involved parties and requires largely underestimated efforts to adapt to the new circumstances.

The paper starts by situating live-in care within the Swiss context of long-term home care. It moves on by reflecting on the concept of familiarity in the framework of home and home care. These reflections inform the presentation of our empirical insights, drawn from a secondary analysis of in-depth interviews with family caregivers. We conclude this article by summarizing how familiarity in the home gets challenged through live-in care arrangements and what this means for the involved persons.

Live-in Care – Transnationally Organized Long-Term Care at Home

As in most European societies, the Swiss long-term elder care system is challenged by demographic developments, cost calculations, and increasingly diversified lifestyles aiming at a maximum of autonomy also when care needs arise. Across Europe, current government policies focus on supporting older people to remain at home as long as possible (Bettio & Verashchagina 2010; Genet et al. 2012). In 2016, 283,528 people of all ages received professional home care in Switzerland; this is an 11% increase in comparison to 2015 and even one of 38% compared to 2011 (Federal Statistical Office 2017). Even though there are still regional differences within Switzerland, available data clearly show a continuous shift into the outpatient sector for already more than a decade (Füglister-Dousse et al. 2015; Werner et al. 2016). Domestic care services are expanded, but in many countries there is still a vast gap between the care needs and the availability of comprehensive care services at home (Colombo et al. 2011). To enable long-term care in private households, both healthcare and social care are essential (Colombo et al. 2011: 46). The latter consists of supportive care tasks such as housekeeping, cooking, social support, and so on. These tasks are of particular relevance for people's ability to stay at home as long as possible, which is both a healthcare policy goal and an individual preference (Otto et al. 2014, 2015). We refer to this broad definition of different forms of health and social care when we talk about long-term care needs in Swiss households.

However, in terms of funding and reimbursing services, the Swiss healthcare system clearly distinguishes between health and social care, whereby a narrow understanding of health, in tendency excluding

nonsomatic aspects, applies. Supporting and supervising a person with dementia, for example, does not count as healthcare. As a consequence, only somatic¹ healthcare services are reimbursed by health insurances, and a family doctor's prescription is required to do so. Social care services, on the contrary, have to be financed out-of-pocket by the persons in need of care (Federal Statistical Office 2015: 2). In consequence, the Swiss long-term home care system heavily relies on families both in terms of funding and personal engagement. Private expenditure for long-term care in Switzerland sums up to a final estimate of about 36% of all costs, which is more than double to the European average (Colombo et al. 2011: 46-47; OECD 2011: 46-47). As a result, the provision of social care and support in household chores are the primary challenges for long-term care provision.

Filling the gaps of unmet care needs, new markets are developing. One of these markets is the mediation of migrant home care workers from economically less privileged regions to work and live in households of people with long-term care needs (Schwiter et al. 2015). Reliable data on the number of live-in migrant care workers are scarce because many migrants do not register in the host countries (Rodrigues et al. 2013), and even if they do, official immigration data often are not sufficiently differentiated in terms of working sectors (Frey et al. 2016). What is known from the literature is that the phenomenon of migrant care workers is closely linked to long-term care and immigration policies of the host countries (Lamura 2013; Rostgaard et al. 2011; Shutes & Chiatti 2012), and to the kind of care regime (van Hooren 2012). For Switzerland, the estimated share of domestic care workers coming from abroad lies between 5000 and 30,000 (Frey et al. 2016). In comparison to Germany, where the number of migrant care workers employed by private households is estimated between 50,000 and 200,000 (Di Santo & Ceruzzi 2010), the Swiss share appears to be rather low. This may be due to the fact that in the Swiss healthcare system there is only very limited cash for care transfer. Hence, if people engage someone for long-term home care, they have to

¹ Measures to monitor and support mentally ill persons in basic everyday coping, such as development and practice of an adapted daily structure or target-oriented training to design and promote social contacts may be reimbursed by health insurances, but only if based on a diagnose of mental illness, which is not the case for dementia.

pay out-of-pocket. Consequently, those who cannot afford this remain dependent on family caregivers or institutional care (van Holten et al. 2013). Nevertheless, live-in care arrangements with migrant care workers are also becoming more and more prevalent in Switzerland (Frey et al. 2016). Domestic migrant care workers mainly come from central and (middle-)Eastern European countries and are mostly women (e.g. Frey et al. 2016; Lutz 2011; Schilliger 2014), well educated (although in most cases not trained in nursing or healthcare), and travel back and forth between the host and the home country (Frey et al. 2016; Rodrigues et al. 2013; Schilliger 2014; van Holten et al. 2013).

The practice of hiring a migrant care worker to live and work in private households, be it for domestic work, child care, and/or care for older people (and sometimes all in one, see Huang et al. 2012), is part of what is referred to as transnationalization of care. We use this term to refer to the recurrent cross-border mobility of care workers and the search activities of those in need of care services. Research on the transnationalization of care “combines structural understandings of global power relations with an emphasis on social interactions between defined actors” (Yeates 2011: 1109). Following this focus on the intertwining of the micro-, meso-, and macro-level, scholars have examined immigration policies and the implementations thereof, concluding that engaging a migrant live-in care worker is not just an individual practice, but also a national strategy, consisting of discourses, policies, and practices that allow and even foster the delegation of care down the economic gradient (e.g. England & Dyck 2012; Shutes & Chiatti 2012; Williams 2012). According to Yeates (2011: 1113), care transnationalization can be viewed as “processes of heightened connectivity evolving around consciousness, identities, ideas, relations and practices of care which link people, institutions and places across state borders.” Hence, care arrangements including a live-in migrant care worker are transnational in the sense that people facing shortcomings of local and national long-term care provision start searching and organizing local long-term care across national borders. Nare (2012: 184) calls this model of families buying in care labour provided by a migrant worker the “transnational market familism” She argues that these dynamics are part of a political economy of care where welfare provision is organized in a transnational context. On a translocal level, these transnationally organized care arrangements involve repeated movements of people between

two (or more) countries and create spaces that span beyond the individual and integrate parts of, respectively, local networks into an emerging new – transnational – network. Furthermore, employing a migrant care worker, rather than providing care within the family, implies a number of transformations, foremost with respect to the home of the elderly person. For example, it hosts new household members, who simultaneously are members of another, distant household and family. As such, the home employing a migrant live-in care worker together with the distant other household of the care worker builds a transnational space of domestic care which transforms the care relationship between the caregiver and the care receiver into a complex relationship between the family caregiver organizing care, the migrant care worker and the person in need of care (see, e.g. Nare 2012). Home care usually establishes translocally dispersed care relations and responsibilities involving the persons cared for at home, family caregivers' homes, ambulant paid caregivers' offices, general practitioners' offices, and people moving between these places. A live-in care arrangement involving migrant caregivers expands these relations, responsibilities, and circulations to distant places across national borders.

For Switzerland, this kind of “transnationalisation of care” is accompanied by an increasing number of scientific studies focusing on diverse dimensions of this phenomenon in the Swiss context. They examine issues such as the experiences of live-in migrant home care workers (Schilliger 2014; Truong 2011), the intermediary practices of agencies (Schwiter et al. 2015; Truong et al. 2012), or the diverse judicial aspects relating to Swiss labor and migration legislation (Medici 2011, 2016). Others investigate the gaps in long-term care provision in terms of funding and services and the corresponding needs of private households engaging live-in migrant home care workers (van Holten et al. 2013), or the experiences of professional home care providers when getting in contact with migrant care workers (Jähnke & van Holten 2013, 2015).

All these papers link the phenomenon of live-in care arrangements in the Swiss context to problematic dimensions of global inequality, to the care chain phenomenon, and to the specific vulnerability of the migrant domestic care workers as well as to marketization and individualization of care. Hence, they frame their work within the overall scientific debate of care transnationalization as illustrated above.

However, little is known about family caregivers' motives, understandings, and experiences with regard to live-in care arrangements (exceptions to this are Chiatti et al. 2013; Petry et al. 2016). This is an important research gap because family caregivers in Switzerland, as well as worldwide, are the backbone of long-term home care. Their contributions – if estimated in monetary terms – clearly exceed annual healthcare costs in the formal sector (Colombo et al. 2011; De Pietro et al. 2015; Rudin & Strub 2014). Family caregivers play a crucial role in providing, organizing, and managing care (Bischofberger 2011; Levine et al. 2010, 2013). As they bear the main caring responsibility, it is usually family caregivers who consider, propose, push, and arrange live-in care arrangements and actually employ live-in care workers (van Holten et al. 2013). Therefore, their perspective is pivotal if we want to know more about why and how live-in care arrangements are formed and how they affect the persons involved (see van Holten et al. 2013).

Method and Data Corpus

This paper is based on interviews conducted by the first author for a study mandated by the Swiss Health Observatory (OBSAN). The study "Care Migration – Transnational Care Arrangements in Private Households" was the first in the Swiss context to take into account the perspective of family caregivers on transnational live-in care settings (van Holten et al. 2013). The project was reviewed by the Institution Review Board (IRB) of the Kalaidos University of Applied Sciences which provided the project with a letter of good standing. Between March and November 2012, eleven interviews were conducted with family caregivers. The interviews were in-depth with a narrative character, lasting 1–2 hours. All the interviews have been transcribed verbatim.

Within the framework of the mandate at that time, all interviews were analyzed by means of structured content analysis (Mayring 2007). The focus of the analysis was laid on family caregivers' reasons and motives for engaging migrant domestic care workers. Main results presented in the study report (van Holten et al. 2013) were the following: family caregivers decide to engage migrant domestic care workers because they strive for stable, comprehensive home care arrangements which – so the shared overall argument – the healthcare system is not able to provide,

neither in terms of material services nor in terms of the desired quality (personal, attentive, individual, flexible, and comprehensive) – at least not within the available cost limits of the interviewed persons (*ibid.*). Hence, the interviews showed that live-in care arrangements with migrant care workers fill in existing gaps of the Swiss long-term home care system.

Due to the narrative character, the interviews provided much more information than was extracted through content analysis. Particularly, the interviews contained sequences concerning difficulties related to (daily) routines, intimacy, autonomy, conflicting social dynamics, and strategies – successful or not – to cope with them. Due to asymmetry and close contact within the private sphere of the home, relationships between employers, care receivers, and migrant care workers tend to be problematic. Kordasiewicz (2015: 54), for example, calls the relationships of employers and their migrant care workers a “sort of a puzzle to be solved in everyday interaction.” Solving this social puzzle may turn out to be very difficult. Therefore, we decided to get back to the data for a secondary analysis to reconstruct these “puzzle-solving strategies” which – as we want to show – are basically linked to the reconstruction of familiarity in the home space.

The process of the secondary analysis used a theoretical coding approach (Strauss & Corbin 1990). It included two iterative cycles of coding (open and axial), including ongoing comparison between the different cases under study and memo writing. Through open coding we identified central analytical categories of live-in care arrangements such as “aging at a familiar place,” “disrupted familiarity,” and “doing familiarity” developed as central themes from the interview data. Through axial coding these categories were differentiated and related to each other, resulting in subcodes such as “compromised privacy,” “sense of alienation,” “transformation of rituals,” “contested autonomy,” or “familiarize the unfamiliar” (see empirical section).

The interview sample consists of five women and six men aged between 37 and 63. At the time of the interviews, apart from one person who had already retired, all interview partners were employed or self-employed; seven were working full-time and three part-time (between 60% and 95% full-time equivalent). Six were graduates, three had a training qualification, and two did not give any information on their educational level. The persons they cared for were between 62 and 99 years old. In nine cases,

the person in need of care was the mother, in one case mother and sister, and in one case the wife of the interviewee. In the last two cases, the interviewee lived in the same household as the person in need of care and in one case the brother of the interviewed person lived together with the mother who needed care. In seven cases, care needs resulted from dementia, partly combined with other diseases such as Sarcoidosis, Morbus Parkinson, and femoral neck fracture. Other persons suffered from apopleptic stroke, from carcinosis, or complaint osteoarthritis of old age. All the interviewed family caregivers not only provided, but also organized and supervised care for their relatives.

Regarding the type of live-in care arrangement, the data covered a wide range, including contracts on a weekly (2), monthly (8), and one on a yearly basis. Except for the last one, they all employed several – mostly two or three – migrant care workers who took turns. Out of eleven settings, eight were mediated by agencies, whereof only one agency was regularly registered in Switzerland and hence fulfilled the criteria for international job mediation under Swiss law. In two settings, the contact resulted from informal networks of the migrant care worker or the family caregiver. One household took over the migrant care worker after their neighbors' death. All care workers were female. They were between 24 and 63 years old and came from Poland, Slovakia, Kosovo, or East Germany, the former territory of the German Democratic Republic (GDR).

Compared to its neighboring countries, live-in care arrangements still are rather new in Switzerland. This is basically due to limited cash-for-care transfers and the restrictive immigration law of Switzerland. Switzerland is a partner in the EU free-movement-of-persons agreement since 2011 and only since then migrants from the new EU countries in Central and Eastern Europe have access to the Swiss labor market. The family caregivers interviewed in 2012, thus, stepped onto unfamiliar terrain when employing a migrant home care worker; they were pioneers, and there were few role models and few people – if any – to turn to for advice. In the meantime, the phenomenon has attracted more attention, and live-in care has gained popularity. However, transnational live-in care arrangements are still far from being a common practice in Switzerland.

Familiarity in the Context of Care

Etymologically, the term “familiarity” stems from the Latin “familiaritas/familiaritatem” which signifies intimacy, friendship, and close acquaintance. Working on memory and familiarity among older people with dementia, Son et al. (2002) define familiarity as “thorough knowledge of a subject derived from a close relationship and acquaintance from past experience” (p. 264). They furthermore refer to familiarity as a *feeling* which occurs as “the product of repeated and frequent exposure to something (e.g. people, objects, scenes, or sounds)” (p. 264). We would argue that this conceptual framing of familiarity as a “feeling” accentuates the potential fluid character of it. It characterizes familiarity as something rather dynamic and potentially fragile which needs to be stabilized by a repetitive time frame pointing to the relevance of frequency and/or continuity. Hence, the feeling of familiarity may be contested when the specific character of the environment (e.g. people, objects, scenes, or sounds) changes. When change occurs, time may play an important role as time may offer (new) opportunities for repeated and frequent contacts within the new environment to (re-)establish a (new) feeling of familiarity. Hence, we understand familiarity, rather than as a given status or fact, as a result of (inter-)action and (repeated) social construction.

We think of familiarity as a social process which – referring to the concept of “doing difference” (West & Fenstermaker 1995) – could be described as “doing familiarity” (see, e.g. Bowlby et al. 1997; Chambers et al. 2009). The need for “doing familiarity” arises when established routines or settings are challenged. We argue that familiarity is an achievement for which people need to work. They invest to create, to restore or to maintain familiarity. Hence, “doing familiarity” may also be seen as the social process of adaptation to social and environmental changes in the context of ageing and developing care needs.

Familiarity becomes fragile for people with chronic illnesses, as care needs progress – even more for those with degenerative conditions such as dementia or Parkinson’s disease. Unfamiliarity creeps in, affects the body and the self, and thereby the most intimate spheres of life. Conditions may change unexpectedly and at any time, one cannot be sure if what one is capable of doing and understanding today is what

one is able to do and understand tomorrow. And as bodies, capabilities, and personalities change, so do the relations with their human and nonhuman surroundings. Hence, also for family members and relatives of persons with chronic degenerative conditions, coping with (un-)familiarity and adapting to the new circumstances may become central. Consequently, adaptation of established familial role models, developed, enacted, and consolidated over years, may be required due to new responsibilities and dependencies that may be completely unfamiliar for those involved.

Precisely because dealing with unfamiliarity and change in the context of chronic degenerative disease is a major challenge, familiarity with regard to care is crucial. However, familiarity has not yet been broadly discussed in the literature on entry to care (Ryan & McKenna 2013). Some studies acknowledge the importance of the concept of familiarity, for example, in the context of nursing home placement of older relatives (Davies & Nolan 2003, 2004; Nolan & Dellasega 2000; Ryan & McKenna 2013), but few elaborate it in detail. Ryan and McKenna's (2013) research is exceptional in this respect. It describes familiarity as "the key factor" of family caregivers' experiences when their older relatives have to move to a nursing home. In their study, Ryan and McKenna's focus lies on the family caregivers' familiarity with the nursing home's history, its staff, and fellow residents. They illustrate how the familiarity of the nursing home is based in the rural social life where professional as well as family caregivers and the older people in need of care had been part of the same community over years. Hence, familiarity results from spending life in a socially well-knot community of which the nursing home is part, and the impact of change associated with nursing home entrance accordingly seems to be less threatening to feelings of familiarity. Davies and Nolan (2004) describe a somehow more (socio-)dynamic and emotionally challenging process of "restoring" a feeling of familiarity when moving to a nursing home by describing three phases of transition: making the best of it, making the move, and making it better. This literature discusses threats to or potential loss of familiarity in the context of making the move from home to a nursing home. Hence, familiarity is threatened by leaving home, and, implicitly, one could say, staying at home is supposed to be kind of a warrant for keeping up familiarity. In this paper, however, we intend to illustrate how home is

becoming unfamiliar through changes in the context of age-related care needs that may challenge specific meanings of the home space and the experiences of familiarity within it.

Home and Privacy – Pivotal Markers of Familiarity

“[H]ome in its broadest sense is a physical, social, psychological (...), as well as political, environment where an individual’s life history with all its relationships contextualised in time and space becomes a part of unpacking meaning and exploring continuity and change” (Peace 2015: 447). This definition stresses that the meaning of home is highly symbolic and that it needs to be understood in the context of the life-trajectories of those emotionally and/or physically “attached” to this particular place. In present-day Western societies, home is generally associated with positive feelings, such as rootedness, intimacy, well-being, comfort, security, warmth, and so on. From feminist research, though, we have learnt not to romanticize home, as it can as well be a site of dominance, violence, conflict, isolation, and entrapment (Peace 2015).

The meaning of home is closely linked to a person’s dwelling, but extends the house or apartment and often includes issues of place – from neighborhood to country; there are “many layers of attachment” (Peace 2015: 448). Belonging is crucial here; home is strongly associated with a sense of belonging. The work of Milligan (2005) on home care is an important source for us: first, she looks at the meaning of home from an informal caregiver’s perspective and from an emotional geography approach. She deploys what she calls an emotiospatial hermeneutic; that is an approach to understand social realities through the emotional component of spaces. Based on this approach, Milligan (2005) identifies three key elements of “home”: (1) the social: relationships between people and interactions; (2) the emotional: feeling of safety, identity, and meaning; and (3) the physical: “incorporates objects and defines boundaries and spaces (and further endows the individual with the power to exclude).” Feelings of familiarity, as introduced above, are closely linked to this conception of home as a space where repeated exposure to people, objects, scenes, or sounds is involved and (shared) biographical experiences lead to an intimate knowledge of this space and, thus, emotions of “feeling familiar.”

The physical and the social undoubtedly are key shapers of home. Home is a place constituted through an assemblage of objects and humans – often placed purposefully, and sometimes arbitrary. Emotionally imbued relations create the gravitational power that brings these heterogeneous elements together, and sometimes drives them apart (again). Therefore, according to an emotiospatial approach, the emotional is superordinate because emotions “alter the way the world is for us” and because “place must be felt to make sense” (Milligan 2005: 2105). In other words, emotions are not only key qualities of relations, material objects, and arrangements, but are a way through which to perceive, interpret, and actually make our environment. Home is commonly perceived as a place, but it is foremost a feeling. Familiarity, a feeling defined as knowing and belonging to socio-material environments (see Ryan & McKenna 2013), is just one, though with respect to home, pivotal example here. Hence, what we call “doing familiarity” may be interpreted as specific social (inter-)actions to create the feeling of familiarity by (re-)making home and redefining the familiar.

However, the “meanings of home in relation to ageing in place are not unambiguous” (Rapoport 2005: 343; cit. in Peace 2015: 447). The notion of “confinement” to home due to, for example, mobility impairments is kind of a “counterpart” which may help to illustrate the kind of ambivalent dimensions of home. So home may be the place where an elderly person is confined to her or his home, which may refer to (1) an unwanted restraint, a limitation or (2) positively viewed – to a place providing security and protection from unwanted intrusion. Although the second dimension is about “[a] feeling of safety within the confines of one’s own house” (Bowlby 2012: 2108), the first one refers to a negative emotion, when leaving home may become difficult as a consequence of raising health and care needs, when the public space is not (easily) accessible anymore, when staying at home is no freedom of choice but a limitation due to restricted mobility.

Most research on the notion of home in care settings focuses on the transition from the private household to a care institution. However, with *ageing in place*, the private household itself undergoes fundamental transformations: Who is entering the household, when and for how long? What happens at home and what is located there? What does the home look like and what kinds of activities are taking place there? Thus, what used to

be familiar about home may be challenged due to care provision at home as well as by changing physical and cognitive conditions. Angus et al. (2005: 161) show that although there is a strong preference for home care from care recipients and their family caregivers, the practices and experiences within their homes are “disrupted and reconfigured by the insertion of logics emanating from the healthcare field,” and that the “domestic and health care fields were superimposed within the space of home,” hence logics of home clash with logics of (professional) healthcare. As we will show, the setting we are focusing on in this paper – that is, migrant live-in care arrangements – mixes this up in a somewhat different way: By introducing paid care provision into the home, the live-in arrangement refers to this “superimposition of the care field on the domestic,” that is, the fact that another logic – namely, the one of paid-for care provision and its market-related dynamics – may become dominant. However, the specific nature of the live-in arrangements we focus on also tends to (re-)establish relationships and practices that clearly refer to the domestic and hence familial logic (see, e.g. Baldassar et al. 2017 on kinning processes between migrant care workers, the care receivers, and their extended family).

Aging in an Ideal and Familiar Place

The interviews illustrate that the main reason for engaging a live-in care worker was a clinging to the idea of home as the ideal place to age and to be cared for, despite increasing need for support. This conviction is related to general social norms and current policies that articulate the home as the ideal place of elder care. Our interviews show that on top of that, the expressed conviction is often rooted in a promise.

This is, for example, what Sarah² refers to when talking about her mother with acute and high care needs due to a complicated fracture after a fall:

I just couldn't imagine bringing her to a nursing home. In those days, earlier, we often discussed the issue and she used to say: “It would be nice if one could die at home.” And I used to reply to her that I respected this wish and that I would do whatever it takes to make it possible. (Sarah)

² All informants' names are pseudonyms.

Also, Barbara who organized a live-in care arrangement for her mother suffering from dementia clearly refers to a promise given to her mother earlier in life:

[...] it was clear she can stay there, yes we promised her that too, she can stay there, she can be on the farm. Since she has lived there for 50 years. (Barbara)

Anna, who organized a migrant care worker because her mother suffered from Parkinson and dementia, while her father getting older himself, could not cover all the care needed, explained that she felt in charge of keeping a promise their parents gave each other:

My father and mother had promised themselves that they would make sure that they could stay at home as long as possible, even if someone became ill. (Anna)

As these three, all interviewees, were bothered with respect to the wish of their mother or father, they felt a clear moral obligation to fulfill this wish and to keep earlier promises. These quotes can be read as manifestations of intergenerational reciprocity duties (see, e.g. Hollstein 2005) and moral beliefs which influence the care arrangement (see, e.g. Kordasiewicz, Radziwinowiczowna & Kloc-Nowak 2018). Looking at family care, informal care, and home care, we have to point to life course-specific needs of care, that is, the “importance of the timescale of the human life course and of intergenerational relationships of care” (Bowlby 2012: 2105). Resulting in a generational interdependency, that is, adults care for (their) children and are “repaid” in their old age by care from their (own) children or by care from other able-bodied adults (ibid.). However, this intergenerational reciprocity debt did not always manifest in such an explicit mode as it does in the presented quotes. Sometimes it was more latent and as a subtext built the basis for feeling responsible of facilitating ageing at home. Referring to Bowlby (2012: 2106), one could argue that these emotional and social links expressed by a promise or by a feeling of responsibility represent what she calls “cultures of care” based in a shared family biography and including “pattern[s] of care behavior amongst families (...) learned over time, through relationships between individuals in place and through space.”

Our analysis shows that interviewees additionally associated the home with key qualities of care such as (1) autonomy and self-determination as well as (2) compassionate, personal, and individual care. On top of this,

some interviewees articulated the home as a therapeutic landscape with the potential to maintain or improve well-being of the person cared for.

It is so important that they feel comfortable and are in their familiar surroundings, even if they live in a completely different time, but when they come back and see, that is still what they are used to...the familiarity of one's own home that is something very important. (Peter)

Like in this quote of Peter who had engaged a migrant care worker to take care of his mother suffering from severe dementia (what he refers to when saying she lives in a completely different time), a familiar environment was repeatedly explained to be a crucial quality of care by all the interviewees. First, doctors would see it as key to cope with dementia, a disease that entails increasing degrees of confusion. Second, a familiar environment was seen as stimulating not only because it allows continuing with simple household chores, but also because neighbors and friends stop by and generate interaction. These statements underpin the meaning of home as a focal point of most people's lives, and the relevance of daily practices involved in maintaining home, such as cleaning, cooking, or caring, which may be understood as domestic rituals that serve to develop the emotional and social meanings of home by "restoring symbolic boundaries and meaningful categories" (Cieraad 1999: 11). Our analysis, though, shows that the continuity of place did not imply continuity in familiarity per se because when an unknown person, that is, in our cases a live-in migrant care worker, enters the home, the very nature of this place changes.

Experiences of Disrupted Familiarity

A Sense of Alienation and Compromised Privacy

In fact, a variety of things change, both material and social. With a "stranger" in the house, there is a sense of alienation. This is what the quote of Sarah makes clear:

I realized that mum had difficulty with somebody being in the house for 24 hours, and a stranger. She would have preferred me to be there, but this was not feasible. (...) I realized that it is strange, for a woman who had lived on her own, had got everything done on her own. But I guess she understood that there was no alternative. (Sarah)

The fact that someone unknown is continuously present in the home is clearly stated as being highly irritating for the mother. Here, a person perceived as a stranger virtually becomes a cohabitant; hence, privacy is compromised because someone nonfamiliar is physically present in the private space of the home around-the-clock. As the quote makes clear, the presence of a more familiar person, that is, the daughter, would have been preferred.

As the mother depends on the care the “stranger” will provide, her endowment to exclude this person from home is compromised. This seems to be specifically challenging as the mother used to be an independent person able to organize her life on her own. What pops up here in addition to the dichotomy of the strange, represented by the live-in caregiver, and the familiar, represented by the daughter, is the issue of dependence as a counterpart to the ideal of autonomy. Although one could argue that becoming dependent is a challenge to the mother-daughter relationship, as shifting responsibilities arise, this seems less threatening than the entrance of the stranger into the home.

Similar to the shifting roles of mother and daughter, dimensions of power are at play as well. Although the daughter acknowledges the emotional challenge the live-in arrangement means to her mother, the daughter makes clear that the more familiar option (i.e. herself being there) is not feasible for her. Hence, her mother does not have a choice; she realizes that there is no alternative solution. To be able to stay at home, that is, the supposed most familiar place, implicates the need to cope with a maximum challenge to the very quality of the same, that is, to deal with the alienation of home by the comprehensive presence of a stranger.

Referring to the literature on ambivalence within intergenerational relationships (see, e.g. Lettke & Lüscher 2002; Lüscher 2005), one could critically question the supposed harmony between family members when comprehensive care needs arise. This is what the following quote of Samuel who engaged a live-in care worker for his 88-year-old mother points to:

It's not all sheer joy - you wouldn't have had vain joy with father either. (Samuel)

Samuel compares the challenging quality of the live-in care arrangement with the potential experience of further living together with her

husband (who had died some years before). Of course, to be cared for by a family member neither guarantees the absence of conflicts nor the presence of harmony. However, care and support would be organized within the established modes and biographically shaped forms of potential conflict or harmony, that is, within the relationship both familiar to the person in need of care as well as to the caregiver.

Transformation of Habits and Rituals

As a consequence of the continuing presence within the home space, the live-in care worker constitutes a significant other. The live-in care worker represents an active subject which wants to get things done, requests responses, and has a professional mission to accomplish. Samuel repeatedly reflected on these challenges in relation to daily routines. His mother and the live-in care worker have to share part of their life with someone who – at least at the beginning – is a stranger, someone from another country who, if at all, only basically speaks their language. They have to develop and implement shared daily routines without really having any joint experiences they could refer to. Hence, they need to negotiate to try to make things clear and to organize tasks and distribute household chores. This may turn out to be rather challenging:

[...] well, now this woman [the live-in care worker] enters my mother's life and begins to take up space and to work according to her own ideas. That's not easy. [...] And my mother couldn't make her needs clear. I asked once in a while when there was a friction: How did you express this to her [the live-in care worker]? And, I said, I understand, because I am your son and I know how she thinks. (Samuel)

The challenge here is not just about a lack of language skills. Rather, the lack of familiarity becomes apparent. The son makes clear that he understands what his mother wanted to express only because they share a joint history. If the mother wants to communicate her concerns, she must do this in a way that is understandable to the live-in care worker. This tangles language skills, but goes far beyond it. Although the content of the communication may refer to intimate daily routines in the home space, one cannot refer to familiar frames of references, as the two persons involved do not (yet) share any joint experiences necessary

for this. Although they do live together, they are strangers to each other. What is needed here is a language that bridges between the individual past of the persons involved and the shared present. Furthermore, there is a need for a specific style of communication that links the intimate quality of the topics (intimate because it is about rituals, habits, individual preferences, and so on) to the fact that the relationship is not (yet) an intimate or familiar one. Hence, one could argue, the professional logic of the arrangement clashes with the domestic one.

Compromised Autonomy and Contested Self-Determination

The entrance of a live-in care worker also transforms habits and challenges familiar rituals in a very profound way. As already stated, daily practices such as cleaning or cooking are basic for creating familiarity in the domestic space (Cieraad 1999). Respectively, food was often mentioned in the narratives, referring to different traditions on how to prepare meals, to what counts as healthy food, or what kind of food one is used to, and so on. Samuel reports about friction points in this respect:

For example, she [the live-in caregiver] thought that, because my mother was having coffee and bread for breakfast, as many elderly people do, that her diet was unbalanced. So, she prepared muesli for breakfast. My mother said: "In my entire life I never had muesli for breakfast." And the carer said: "This is healthy." My mother said: "That's true, but I don't have muesli for breakfast." [The carer replied:] "Nevertheless, you eat breakfast, it's healthy." These are the kinds of things the two didn't really get along. (Samuel)

Food debates like this one illustrate the multifold dynamics of the superimposition of the foreign, that is, unfamiliar logics into the familiar daily routines of the home space. In this quote, the live-in caregiver in fact takes her job rather serious and wants to optimize the diet of the person in need of care – also against her will. Samuel further reflected on the fact that his mother felt oppressed and also explicitly expressed that she "did not want to obey." She obviously thought she'd left these things behind at her age. What is central in the quote in relation to familiarity is the term "in my entire life" which clearly refers to rituals and habits that are challenged by the introduction of a new diet for breakfast considered to

be healthier by the migrant care worker. Again, power dimensions³ turn out to be crucial as well as a tension between the professional mission of the live-in care worker and the habits and preferences of the person in need for care.⁴

“Doing Familiarity” – Ways to Cope with New Situations

The interviews illustrate a range of conflicting power dynamics represented through the attempts of mutual domestication of the person in need of care and of the live-in caregiver, which may be summarized into the question: Who adapts how and to which changes? The interviews reveal a variety of adaptations to the new situation. Generally, we could find two ways of dealing with change and unfamiliarity in the interviews: (1) adaptation to the new situation, and (2) introduction of another change to circumvent unfamiliarity.

One form of adaptation is to transform the unfamiliar into a familiar thing. For example, both the person in need of care and the live-in care worker might accept changing their habits. This includes reinterpreting and adapting over time. And often, it does not go without conflicts. Family caregivers turned out to put in a lot of time and effort to mediate between the cared-for and the live-in care workers. Making the unfamiliar familiar by reinterpreting and adapting is a strategy that also applies to the live-in care worker as a person. The interviews contain various instances that indicate that the subject position of the live-in care worker is shifted from a strange outsider and a paid-for care worker to a member of the family.

The caregiver can become part of the family. She was part of us somehow. We spent a lot of time together. I mean, I was there every day. And although it was only for two weeks, a bonding developed. (Sarah)

³ It is important to note that power asymmetries exist between the live-in care giver and the person in need of care or his/her family in both directions. As a consequence of our focus on the notion of familiarity in live-in care and how it is negotiated by the interviewed family caregivers, however, the vulnerable dimension of the live-in care worker is less addressed in our data.

⁴ Although live-in caregivers usually come from places that are deemed culturally different from Switzerland, reference to cultural differences was largely confined to food and cooking habits. Consistent with van Holten & Soom Ammann (2016), cultural difference was largely used to explain irritating behavior and encounters in our data set.

Thus, adaptation is here done via attempting to redefine the “stranger” as “being part of the family.” When employed caregivers become quasi-family members, their position in the social network changes. This strategy, also referred to as “kinning process” (Baldassar et al. 2017), refers to kinship as something not constituted by pure biological ties but rather as something “fundamentally relational and performative” which is “negotiated on a daily basis through diverse activities, with caregiving being the most significant” (Baldassar et al. 2017: 526).

Moving away from the subject position of a paid worker, however, blurs the boundaries between leisure and work even more (see Truong 2011). Some caregivers, for example, were invited to family events, and, although they started to take care of the guests or to clean the kitchen, their participation was considered as spare time. One migrant caregiver even accompanied the person in need of care and her family caregiver to a holiday, but it was framed as the caregiver’s holiday, too. However, as compassionate care is viewed as crucial, it also renders the live-in caregiver as non- or at least less replaceable. This increases the household’s dependency on them. So, shifting the live-in caregiver’s subject position toward a family member implies complex asymmetries and can simultaneously work to the advantage or disadvantage of the live-in caregiver.

Time and continuity are two central aspects of adaptation and doing familiarity. Adaptation is described in the interviews as a mutual approach, getting to know each other, and getting “closer.” This requires an intensive learning process for all involved, at the end of which familiarization potentially can take place. This is illustrated by the following quotation, in which Samuel reports on everyday situations that have meanwhile become harmonious:

And now so over the two and a half years they have got used to each other and know how the other one thinks, and that has also relaxed a little bit.[...] When I sometimes visit them and I see them sitting in front of the big window, looking down into the valley and drinking coffee, so harmoniously together, then I have the feeling that it can’t be that bad. Or when I see them working together in the garden and planting creatively in a way and, afterwards I think, it’s still in a way a hand-in-hand walk. (Samuel)

However, the described familiarity remains a fragile achievement, which can be contested at any stage. Continuity and regularity are important prerequisites. Often, family caregivers tried to extend the working contract

to achieve more continuity, which was not always possible due to restrictions of the intermediary agency, restrictive migration policies or individual preferences of the migrant care worker. Those arrangements in which turn-taking of the migrant care workers was very frequent or where they only stayed for a short time, that is, 1 or 2 weeks, and did not come back again were considered as unsatisfactory by the interviewees. This may be understood as a direct consequence of the failure of restoring familiarity over time. Nevertheless, when the same two or three migrant women took turns, a certain familiarity could be achieved. What was striking here was that usually one of the migrant women stood out as particularly reliable and delivering extraordinary care services in comparison to the other care workers involved. This may be seen as an attempt to construct one main caregiver among the changing caregivers who stands out due to specific individual characteristics and hence fits the care arrangements at its best. Hence, this represents a further realization of the “doing familiarity” strategy.

Another form of adaption is to accept the new as something unfamiliar that might well remain strange. This includes a transformation of the notion of home; it now includes unfamiliar elements. The unfamiliar elements might not be bothering or they might be the bitter pill one is ready to swallow for the higher aim of staying at home. The last sentence of the first quote indicates this trade-off: “But I guess she realized that there was no alternative.”

Conclusions

Based on the analyses we intended to illustrate that familiarity is a result of (inter-)action and social construction, rather than a given status or fact. Hence, we understand familiarity as relational; it describes a dynamic relation between persons, their resources, and their environment. Furthermore, familiarity is associated with recognition, repetition, continuity, stability, and safety, with time and space being further relevant factors of familiarity, pointing to the experiences in the past and the meanings of specific places such as, for example, the home. Hence, we understand familiarity as a condition that is threatened by change.

Change, that is, encountering new environments and situations, is challenging or even shattering familiarity by evoking feelings of unfamiliarity. Experiencing unfamiliarity may result in not only alienation

and confusion but also curiosity to explore and understand the novelty. With time and through reinterpretation and adaptation, the new situation might be integrated into a relation of familiarity to a new set of entities, and familiarity might be restored. Or change leads to a lingering feeling of strangeness. We call this reinterpretation and adaptation to change the “work” that is needed to achieve familiarity. This further implies that familiarity is a precarious condition, always at risk of being questioned or brought down.

Hiring a live-in caregiver allowed care recipients to stay at home and family caregivers keeping their promise to facilitate ageing at home. Hiring a live-in caregiver did not, though, allow continuing some of the core qualities that were associated with home care. As we have shown, autonomy and privacy are both compromised, at least temporarily. This is important because often they were the very reason to maintain home care and hire a live-in caregiver.

Autonomy and privacy are both closely linked to control. Milligan (2005: 2107) notes: “The transition of care to a care-home setting marks a clear shift in the balance of power in the caregiving relationship from informal to formal caregivers. Informal carers and care recipients lose the ability to exclude” and define the terms of how care is delivered. While with a live-in care arrangement the family caregiver and care recipient keep in control to some extent, we have also shown that this control, due to the complex asymmetries at work, can be rather limited and need to be worked on.

Our empirical data suggest that there are different ways of dealing with threats to familiarity. All of them imply work: adapting to or searching for new arrangements entail efforts, emotional and physical. The interviews clearly showed that taking in a live-in caregiver entails change that is not easily shrugged away for all involved parties. For some, the price is too high. If the effort to adapt and re-establish familiarity at home was considered too intensive or not worthwhile, the agreement with the live-in caregiver was resigned and the person in need of care had to enter a nursing home.

Research has highlighted that care migration entails a problematic transnational transfer of care work. Caregivers who come to work in Northwestern European countries are missing in their home countries. Our research offers a more nuanced picture on the nitty-gritty everyday

life in live-in care arrangements, and it reveals the complexity of adapting to it. Foremost, it challenges the idea that remaining at home is about continuity. It probably is as much about change as moving to a nursing home.

Corresponding Author

Karin van Holten, Careum School of Health, Kalaidos University of Applied Sciences, Pestalozzistrasse 5, 8032 Zurich, Email: karin.vanholten@careum-hochschule.ch.

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Live-in migrant care worker arrangements in Germany and the Netherlands: motivations and justifications in family decision-making

By VINCENT HORN¹, CORNELIA SCHWEPPE², ANITA BÖCKER³ & MARÍA BRUQUETAS-CALLEJO⁴

Abstract

Private households in ageing societies increasingly employ live-in migrant carers (LIMCs) to care for relatives in need of 24/7 care and supervision. Whilst LIMC arrangements are a common practice in Germany, they are only recently emerging in the Netherlands. Taking this development as a starting point, this study uses the countries' different long-term care (LTC) regimes as the analytical framework to explore and compare the motivations and justifications of German and Dutch family carers who opt for an LIMC arrangement. Findings show that Dutch and German LTC regimes impact differently the decision-making processes of families, as well as on patterns of justification, through a combination of policies and social norms and their related expectations towards care and care work in old age.

¹ *Vincent Horn*, Institute of Education, Johannes Gutenberg University Mainz, Mainz, Germany

² *Cornelia Schweppe*, Institute of Education, Johannes Gutenberg University Mainz, Mainz, Germany

³ *Anita Böcker*, Department of Sociology of Law and Centre for Migration Law of the Law Faculty, Radboud University, Nijmegen, The Netherlands

⁴ *Maria Bruquetas-Callejo*, Department of Sociology of Law and Centre for Migration Law of the Law Faculty, Radboud University, Nijmegen, The Netherlands

Keywords: families, Germany, live-in migrant carers, long-term care, older people, The Netherlands.

Introduction

The provision of adequate and fiscally sustainable long-term care (LTC) for older people poses a major challenge to ageing societies (OECD 2017). Not only are governments faced with a rapidly growing proportion of older people in need of LTC, but changing family structures and increasing female employment in several European countries simultaneously diminish the pool of informal care providers (Cangiano 2014; Colombo et al. 2011). This development has led to an increasing demand for live-in migrant carers (LIMCs) in private households, although their prevalence varies considerably across European countries (Di Santo & Ceruzzi 2010; Van Hooren 2012). Whilst LIMC arrangements have become a widespread practice in southern European countries and to a lesser extent in Austria and Germany, they are practically absent in Nordic countries and are just emerging in the Netherlands (Da Roit & Van Bochove 2017; Da Roit & Weicht 2013).

Theoretically, cross-country differences in the prevalence of LIMCs have been explained by variations in national LTC regimes (Bettio et al. 2006; Da Roit & Weicht 2013; Van Hooren 2012). Because Germany and the Netherlands represent very different LTC regimes and traditions (Bettio & Verashchagina 2012), they are interesting cases to compare. The Netherlands introduced an LTC insurance as early as 1968, providing a broad range of largely publicly funded health and social care services (Maarse & Jeurissen 2016). By contrast, Germany's LTC insurance, which went into effect nearly 30 years later in 1995, still leaves most of the responsibility to the families (Wetzstein et al. 2015). The strong reliance on the family largely explains why the demand for LIMC arrangements in Germany is higher than that in the Netherlands (Böcker et al. 2017). However, recent studies have indicated an emerging, although still small-scale, market for LIMCs in the Netherlands as well (Da Roit & Van Bochove 2017). This development occurs in a time of significant policy changes in the Netherlands, which intend to foster deinstitutionalisation and deprofessionalisation in its LTC regime.

Thus far, comparative studies of LTC regimes and migrant care workers have clustered countries according to specific combinations of care, migration and employment policies, but have paid limited attention to the role of families in this process. However, the concept of a regime not only refers to a set of policies and their interconnections but also explicitly points to the relation between policy and culture and how this relation influences care preference and everyday care practices and experiences at the micro-level (Bettio & Plantenga 2004; Williams 2012). According to this approach, care preferences and choices are informed by mutually influencing policies and social norms about caregiving, family and gender relationships (Anderson 2012). Social norms about caregiving engender expectations about family obligations as well as appropriate care arrangements and practices. At the same time, these social norms are more than just rules which simply get applied: "Their importance enters the scene through a sense (...) that there is an external audience who observes what goes on and make judgments about it" (Finch & Mason 1993: 27). Moreover, social norms about caregiving are no fixed entities; they can be challenged through policy change and social actors such as organisations, families, etc. (Pfau-Effinger 2005).

This article takes up this understanding of regime as a sensitising concept to analyse and compare the motivations and justifications of family decision-making in hiring an LIMC in Germany and the Netherlands. Concretely, the article addresses the following research questions: What motivates German and Dutch families to employ an LIMC and how do they justify their decision? How do their motivations and justifications relate to institutional, cultural and political factors in both countries? In the first section of this article, the scope and features of LIMC arrangements in Germany and the Netherlands are described using both secondary literature and insights gained from stakeholder interviews.¹ In the second section, the different prevalence of LIMC arrangements in the two countries is explained by comparing the different LTC regimes. In the third section, findings from semistructured interviews with 24 German and

¹ Besides semi-structured interviews with 24 primary family carers, stakeholder interviews were conducted as part of a mapping study, 28 in the Netherlands and 14 in Germany.

Dutch primary family carers are presented and discussed in light of the different LTC regimes and recent reforms in LTC in both countries.

Scope and Features of LIMC Arrangements

Demographically speaking, Germany and the Netherlands experience the ageing of their societies at a similar pace. In both countries, the population of over 80 year olds – the group with the highest risk for needing LTC – has grown by almost one-third during the last decade (OECD 2017). With 5.6%, the share of this population group is slightly larger in Germany than in the Netherlands (4.3%), as is the number of people with dementia per 1000 inhabitants (20.2 vs. 16.1, OECD 2017). The growing demand for LTC has led to the widespread use of LIMCs in Germany, whereas in the Netherlands, this development has not taken place (Böcker et al. 2017; Da Roit & Van Bochove 2017). According to a recent representative study by Hielscher et al. (2017), 11% of German households with a dependent older person employ an LIMC. With 2.1 million older people receiving LTC insurance benefits at home, approximately 200,000 LIMC arrangements are currently existing in Germany. By contrast, it is estimated that less than 1000 older dependents in the Netherlands make use of an LIMC arrangement (Da Roit & Van Bochove 2017; Van Bochove et al. 2017; Van Grafhorst 2014).

The dominant mode of employing LIMCs in Germany is through informal arrangements between families and LIMCs (Kniejska 2016). As argued by Lutz and Palenga-Möllenbeck (2010), the German state has become an accomplice in the emergence and establishment of a large informal care sector by “knowing and pretending ignorance at the same time; acting officially in a restrictive way, while tacitly accepting the violation of self-made rules” (p. 426). Indeed, a solid legal basis for sanctioning employers was established with the 2004 Law Against Illegal and Irregular Employment (*Gesetz zur Bekämpfung der Schwarzarbeit und illegalen Beschäftigung*). Nevertheless, there have been very few investigations of the private household sector (Scheiwe 2010). The main reason for private households being rarely accused, is that workplace inspections as a measure to detect irregular employment are largely limited to the country’s construction and catering industry, two other sectors well known for irregular employment. In other words, despite the official rhetoric and available legal sanctions against employers, there is little political will to intervene in the private household sector.

Parallel to this informal care market, a formal market for LIMCs has emerged, with placement agencies as a central actor (Rossow & Leiber 2017). As calculated by the German consumer organisation and foundation Stiftung Warentest (2017), more than 250 LIMC placement agencies are active in the country.² According to the spokesperson of an umbrella organisation, the Verband für häusliche Betreuung und Pflege e.V. (VHBP),³ around 30,000 households are currently using the services of these agencies. Commonly, the LIMC placement agencies cooperate with care service providers and/or temporary employment agencies in Poland, but increasingly also in other Eastern European countries such as Croatia, Hungary or Slovakia (Krawietz 2014). Like their counterparts in the black labour market, LIMCs usually commute between the household in Germany and the household in their country of origin for periods of between 1 and 3 months.

Initially, placement agencies primarily placed self-employed LIMCs in German households (Neuhaus et al. 2008), but more recently they have increasingly made use of the EU Posted Workers Directive (Stiftung Warentest 2017). This means that the LIMCs have a working contract with the employer in the sending country. In other cases, LIMCs are formally contracted by German families as home helps without the involvement of placement agencies. In this case, families act as employers and have to pay payroll tax and social security contributions for the LIMC. Depending on the type of employment, costs can range from around 500 to 1800 euro per month for an irregularly employed LIMC (Kniejska 2015), and up to 3400 euro per month for an LIMC hired through a placement agency (Stiftung Warentest 2017).

Unlike in Germany, most users in the Netherlands hire their LIMCs through LIMC placement agencies. According to our mapping study, there are currently about 20 agencies active in the Netherlands, of which most were founded after 2010. Like in Germany, most of these placement agencies cooperate with temporary employment agencies or care services providers in Central and Eastern European EU member states. The care workers are recruited and often also employed (and then “posted” to the Netherlands)

² Most of the LIMC placement agencies operate at the local or regional level and are highly diverse with regard to staffing, number of clients, employment modes and cooperation models.

³ In the VHBP, 35 of the largest LIMC placement agencies in the country are organised.

by these partners. However, there are also placement agencies that operate differently, for example, employing the LIMCs themselves and then placing them with clients in the Netherlands, asking their clients to act as employers or asking the LIMCs to work on a self-employed basis. The costs for the client amount to between 2500 and 3000 euro per month for one LIMC. A minority of the Dutch users recruit and employ their LIMCs themselves, without making use of the services of placement agencies. However, our assessment is that cases of informal employment are very rare in the Netherlands.

Explaining Cross-Country Differences

Cross-country variations in the prevalence of LIMC arrangements can be explained by different types of LTC regimes. As argued by this approach, different distributions of responsibilities between the state and the family shape the demand for LIMCs, in combination with migration and employment regimes (Da Roit & Weicht 2013; Van Hooren 2014). Accordingly, the demand for LIMCs is assumed to be high in countries with low public expenditure on LTC, a large underground economy and extensive undocumented migration (Da Roit et al. 2007; Gori 2012; Van Hooren 2012). Medium demand for LIMCs is assumed for countries with low public expenditure on LTC, unregulated cash-for-care benefits and a high proportion of unskilled workers in the LTC sector (Da Roit & Weicht 2013). Finally, the demand for LIMCs is assumed to be low in countries with high public expenditures on LTC, regulated cash-for-care benefits, a limited underground economy and a highly professionalised LTC sector (Da Roit & Weicht 2013; Van Hooren 2012).

The first set of factors is characteristic for countries with familistic LTC regimes, like Italy or Spain (Bettio et al. 2006; Di Santo & Ceruzzi 2010). Germany, together with Austria, is part of a group of countries combining the second set of factors. LTC regimes in these countries can be described as publicly supported private care regimes in which the family has remained the primary caring unit (Bettio & Plantenga 2004). The Netherlands, Sweden and Norway represent countries combining the third set of factors (Da Roit & Le Bihan 2010; Da Roit & Weicht 2013; Van Hooren & Becker 2012). In these countries, LTC is seen primarily as a public responsibility, and consequently, a high level of subsidies for using LTC services is provided (Lipszyc et al. 2012). A comparison of the

German and Dutch LTC regimes shows that both countries maintained their position in this taxonomy but that convergence can be observed in policies aiming to promote home-based LTC arrangements.

As shown in Table 1, the Netherlands spend a far higher share of their GDP on LTC services than Germany (3.7% vs. 1.3%). By contrast, private spending on LTC services is much higher in Germany. In 2008, co-payments and direct out-of-pocket costs made up 32.9% of the expenditure on ambulatory and institutional care services in Germany, compared to less than 1% in the Netherlands (Lipszyc et al. 2012). Residential care for severe LTC needs puts an especially high financial strain on the budgets of German LTC recipients (Statista 2018). In light of this, it does not come as a surprise that according to a representative study, 54% of Germans would opt for an (informal) LIMC arrangement to avoid the high contributions to residential care (Bange & Röthing 2007). With the last policy reform, the *Pflegestärkungsgesetz 2* from 2017, German policymakers strengthened the existing system: whilst the maximum amount for cash benefits paid in case of informal home-based LTC was increased by 24%, the maximum amount for in-kind allowances used for residential care remained virtually unaltered. In the Netherlands, on the other hand, user contributions for residential care have been raised considerably in the past few years, but the amount of the contribution depends on one's income and wealth, so

Table 1. The Dutch and German LTC regimes

	Germany	Netherlands
Public LTC expenditure as share of GDP ¹	1.3%	3.7%
Share of LTC recipients aged 65+ receiving care at home, 2015 (2005) ¹	69% (64%)	71% (65%)
Share of LTC recipients aged 65+ receiving only cash benefits	54.2 % ²	4.7% ³
LTC beds in institutions and hospitals per 1000 population aged 65+, 2015 ¹	54.4	87.4
LTC workers per 100 people aged 65+, 2015 ¹	1.9 (home) 3.2 (institution)	3.2 (home) 4.8 (institution)

Sources: ¹OECD 2017; ²Statistisches Bundesamt 2017, own calculations; ³Centraal Bureau voor de Statistiek 2018, PGB, LTC recipients 65 and older.

that residential care remains financially accessible for LTC recipients in all income groups.

In both countries, a similar and increasing share of LTC recipients receives care at home. However, whilst in Germany, 66% of these LTC recipients are cared for by family carers only (Statistisches Bundesamt 2017), their Dutch counterparts are much more likely to receive support from professional home care and/or household help services. The Dutch LTC system has undergone substantial reforms over the past few years. Only people who need constant care or supervision are entitled to benefits under the new LTC Act (*Wet langdurige zorg*). Simultaneously, the responsibility for organising the care for people with lighter care needs has been decentralised to local authorities under the new Social Support Act (*Wmo 2015*). One of the aims of this decentralisation was to foster the replacement of (publicly subsidised) household help and other professional care services by informal care. However, recent research shows that this aim has not been realised (Bredewold et al. 2018). There appears to be a discrepancy between, on the one hand, the underlying premises of the recent and ongoing LTC policy reforms and, on the other hand, the trend in care ideals among the population, which at least until recently was towards, rather than away from, care ideals in which the family has only a very limited responsibility for the provision of care for the frail old (Van den Broek 2016).

The German LTC insurance promotes family-based LTC arrangements through a combination of strict eligibility criteria for residential care and largely unregulated cash benefits (*Pflegegeld*). The cash benefit is paid directly to the dependent person with no need to provide proof of its use, making it relatively easy to spend the money on hiring an LIMC. However, depending on the degree of dependency (*Pflegegrad*), cash benefits range from 316 to 901 euro per month and do not cover the entire costs for an LIMC arrangement as mentioned in the previous section. Nevertheless, for more than 50% of LTC recipients aged 65 and older in Germany, the *Pflegegeld* is the only benefit received from the LTC insurance. If only those are looked at who are cared for at home, the share even increases to 81%, indicating that in many private households, LTC is provided informally.

By contrast, in the Netherlands, only 4.7% of LTC recipients aged 65 and over received a cash benefit [*persoonsgebonden budget (PGB)*] under the

new LTC Act in 2016 (Monitor Langdurige Zorg 2018, own calculations). The difference is even more remarkable as the average monthly cash benefit in the Netherlands is significantly higher than that in Germany (3400 euro) (Sociale Verzekeringsbank 2016; see also Mosca et al. 2017). The low propensity of Dutch LTC recipients to opt for cash benefits can be explained in part by the comparatively generous in-kind allowances and in part by the tight regulation and supervision of these payments (Da Roit & Le Bihan 2010). Unlike in Germany, the money is not paid directly to the dependent person and application and reimbursement procedures involve a lot of paperwork (Mot 2010; Sadiraj et al. 2011). The regulation of cash benefits impedes Dutch LTC recipients from using the money to informally employ an LIMC and helps explain why LIMCs in the Netherlands are hired through a placement agency, if they are hired at all (Da Roit & Van Bochove 2017).

Table 1 shows that the number of LTC beds in the Netherlands is much higher than in Germany. Nevertheless, there has been a clear trend away from residential care. Whilst in 1995, 25% of the Dutch population aged 80 years and older were residing in residential care homes, the proportion dropped to only 12% in 2017 (Centraal Bureau voor de Statistiek 2018, authors' own calculations). This development can be seen as the outcome of a change in preferences away from residential care and towards home-based care both among policymakers and among older people themselves. To reduce LTC expenditures, Dutch policymakers made the promotion of home-based and informal care arrangements an explicit policy goal (Grootegoed et al. 2015; Mot et al. 2010; Tonkens 2011). Deinstitutionalisation has clearly been more successful than deprofessionalisation. However, there are signs that the trend towards deinstitutionalisation is reaching its limits. There is an increasing concern that home-based care does not or cannot fulfil the care needs of a growing group of vulnerable older people who, until recently, would have (been) moved to a residential care home. At the same time, concerns about the quality of residential care (especially the lack of personal attention) have resulted in large amounts of money being reserved to secure and improve it.

In Germany, the ratio of LTC workers (in home-based as well as institutional care) to the population aged 65 and older is much lower than in the Netherlands. This difference also reflects the acute shortage of LTC workers in Germany, which is inextricably linked to the difficult working

conditions in this sector characterised by relatively low pay and a high work load. Understaffing adds to broader criticism towards residential care homes in Germany, including the prioritisation of organisational rationalities, particularly cost-effectiveness, at the expense of a more individualised care approach, the dominance of the medical paradigm at the expense of the social and emotional aspects in care and an increasingly visible standardisation of care (Behr 2015; Greß & Stegmüller 2016). Concerns about the quality of care provided in residential care homes are nurtured by media reports and studies about abuse and neglect (MDS 2017; ZQP 2017). Often reinforced by biographical experiences, these concerns fortify a widespread “institutionalisation aversion” (Costa-Font 2017) and partly explain the high moral pressure to arrange home-based LTC in old age. However, the high value placed on home-based LTC arrangements puts considerable burdens on family carers, with several studies revealing the negative impact of their situation on their social and physical well-being along with financial constraints (Bestmann et al. 2014; Pinquart 2016).

Data and Methods

This study is part of the comparative research project “The Emergence and Significance of Transnational LTC Arrangements in Germany and the Netherlands.” To gain insights from various angles, semi-structured interviews with different actors involved in LIMC arrangements (e.g. family members, care recipients and LIMCs) were conducted between May 2016 and March 2018 in both countries. The main selection criterion for households was the current or earlier employment of an LIMC. Family members were selected according to their role as primary family carers who as such were involved in various forms of support, including administrative tasks as well as caring activities. For the Dutch part, the study was reviewed and approved by the Ethics Committee Faculty of Law/Nijmegen School of Management of Radboud University Nijmegen (registration number 2016.11). For the German part, no ethical approval was requested by the Johannes Gutenberg University Mainz.

To explore the families’ motivations and justifications for using an LIMC arrangement, we analysed 39 interviews (including follow-up interviews) with 14 primary family carers in Germany and 10 primary family carers in the Netherlands. Follow-up interviews were conducted to clarify questions

and capture changes in the LIMC arrangement over time. The initial aim was to interview the care recipients as well. However, oftentimes, this was not possible due to cognitive and/or health impairments. The same interview guideline was used in both countries, covering four broad themes: (1) reasons for establishing an LIMC arrangement, (2) structure of the arrangement (e.g. mode of employment, duration, etc.), (3) everyday care activities and (4) assessment of care provided. The interviews took place at the respondents' place of choice, with some preferring the care recipients' household and others being more comfortable in a different location.

In both countries, respondents were primarily the children of the care recipients. In Germany, the children were in their 50s and 60s and varied considerably regarding their socio-economic profiles and family situation. Some lived in the same house as their parent, whilst others lived several hundred kilometres away. The latter periodically moved into their parents' house to either support or swap with the LIMC. In the Netherlands, the children were of a similar age as their German counterparts, their family situation varied, but they were less heterogeneous in terms of their socio-economic profiles and geographic location. The majority was higher educated, employed full-time and lived less than 20 km away from the care recipient. In three cases in Germany and two in the Netherlands, the family carer was the care recipient's spouse or partner. All German spouses were males in their 70s and had cared for their wives for several years by themselves before taking the decision to employ an LIMC. The Dutch spouses were women of working age with a demanding job and/or study.

Field entry and sampling was difficult in both countries, although for different reasons. In the Netherlands, the main obstacle was that LIMC arrangements are still rare, and consequently, chain referrals were of little use. Most respondents could only be recruited via LIMC placement agencies, using a clustered sampling technique. In a few cases, the care recipient was already deceased at the time of the interview or the family carer had quit the arrangement for a variety of reasons. By contrast, in Germany, the main obstacle was the respondents' reluctance to participate because of the irregular employment situation of the LIMCs. Snowball sampling through personal contacts was therefore particularly useful to find interview participants. Key informants from LTC services were also

helpful in establishing contact with family carers but often perceived our request as an additional burden. Attempts to recruit respondents through care associations, parishes, placement agencies and through a Facebook site proved to be of little success. Altogether, in eight care arrangements in Germany, the LIMCs were employed irregularly, in five placed by an agency and in one case, the LIMC was directly employed by the family.

In both countries, all LIMCs came from Central and Eastern European EU member states. In Germany, the majority came from Poland and some from Romania and Slovakia. In the Netherlands, the majority came from Slovakia. Others came from Romania, Poland, Bulgaria and Hungary. At the time of data collection, all but one of the LIMCs employed by Dutch and German families were women. Their age ranged from 30 to nearly 70 years, with an over-representation of women in their 40s and 50s. Most were married and had a husband and children living in their country of origin. The women's educational background was very diverse. They usually completed secondary education and were trained in very different professions (e.g. accountant, craftswoman and teacher). Only very few were trained as nurses, and some who were employed by an agency received a crash course in caring before taking up their first job. Thus, most caring knowledge was based on experiences with frail and older family members. Many had worked for several German or Dutch families already and considered themselves fairly well prepared for this job.

Data collection and analysis was done in Dutch and German and all interviews were audio-recorded and transcribed verbatim. We used a two-step analysis for the empirical data. Firstly, we analysed each case as a whole, to reconstruct the narrative of motivations and justifications in the context of its particular constraints and opportunities. In this step of the analysis, we focused on how primary family carers made sense of their choice for an LIMC arrangement, including both objective aspects (such as specific events, health deterioration and financial constraints) and subjective ones (arguments, care ideals, preferences and values) behind the decision. Secondly, we analysed interviews thematically, using a combination of inductive and deductive codes. Based on our research questions, we searched the data for answers to three sets of questions: (1) concrete reasons triggering the choice for using LIMCs, (2) aims and motivations of family carers and (3) justifications for establishing a transnational care arrangement. Within each of these questions, we identified recurrent

individual arguments, which were grouped into themes. Throughout this process, the interviews of the Dutch and German cases were analysed separately, and subsequently results were compared to identify differences and similarities. Finally, we tried to make sense of the cross-national differences, by setting different motivations and justifications against the national institutional framework of LTC regimes.

Reasons and Motivations

In both countries, the main triggers that lead to an LIMC arrangement were changes that required a modification in the actual care of the care recipient. The need to look for different care arrangements emerged from a deterioration of the care recipient's health condition, be it by an aggravation of a condition such as dementia, Parkinson's disease, stroke, old-age frailty and/or a combination of these, or by sudden crisis events such as the death of the care recipient's spouse or a fall with serious injuries. The previous care arrangement, usually involving a combination of informal and ambulant home care and/or day care services, became unfeasible, or a living arrangement in the private home without the provision of care was no longer possible.

Preventing Residential Care

In both countries, the search for a new care arrangement was conducted with the principle aim to prevent the care recipient from having to move to a residential care home. This aim was based on two closely linked factors. One was the care recipient's wish to stay at home and the family carers' desire to meet this preference. The other resulted from the negative associations of care recipients and family carers about residential care homes, especially among respondents in Germany. Rather than as an alternative, residential care homes were perceived as a last resort, a measure to be taken only when all other possibilities have been exhausted. Accordingly, avoiding the worst case was the starting point of the family carers' search for solutions. As put by one care recipient's son: "The focus was always that he shouldn't move to a residential care home. And then I looked, how can we do that?"

For the German interview partners, a strongly internalised responsibility and a felt moral obligation to care for a spouse (or parent) *oneself* were

closely related to the preference for home care and for avoiding residential care, as illustrated by the following quote of a caregiving husband:

As I said, I feel committed to her. I also said, okay, that's my wife and that's just what she is, right? And that's the way it is, I don't know why. But if I had to put my wife into a residential care home today, that would be really hard for me. PN7, spouse of care recipient, middle level education, secondary

In this respect, hiring a migrant care worker does not only allow for the care recipient to stay at home, but is also a way to deal with the inner turmoil of the German family carers who feel overburdened but incapable to move their dependent relatives into a residential care home.

For the Dutch family carers, too, the principal aim was to enable the care recipient to stay at home. However, their arguments were different from those of the German respondents. Not all had a negative image of residential care in general. Instead, they emphasised that it would not be a suitable option for their parent or spouse. For example, a son who had moved his older parents back home from a residential care home explained: "I had the feeling – despite the good care and the good intentions of the people that were looking after them – that they were depressed." Other respondents pointed out that the care recipient had never felt comfortable in a group or that he or she had always attached great value to having autonomy and being able to pursue his or her own lifestyle. The arguments of the Dutch respondents thus referred more to the (individual) perspective of the care recipient.

A More Personalised, Holistic and Stable Provision of Care

Both German and Dutch family carers emphasised that opting for an LIMC arrangement was closely linked with their preference for a more personalised and holistic provision of care. They agreed that this type of care could not be delivered in residential care homes due to poor staff to care recipient ratios and high turnover rates. Personnel continuity also played a role when deciding against other possible LTC arrangements, for example, those involving ambulant care services. Constantly changing ambulant care workers were thought to have a destabilising effect on the care recipient's mood, causing aggressive and rebellious behaviours,

as the son of a Dutch care recipient said. With the stable presence of an LIMC, the care recipient would become more calm and balanced. Generally, family carers in both countries appreciated personnel continuity and the development of trustful, family-like relationships between the care recipient and the LIMC.

Lowering Family Care Burdens

Besides the preference for a stable and individualised care arrangement, German family carers in particular sought to reduce their organisational effort by employing an LIMC. Particularly those with competing commitments (e.g. work, children) often had to search for a quick, stable and uncomplicated solution to their relatives' need for around-the-clock care and supervision. Most found it very challenging to combine different care services (e.g. ambulant care service, day care centres) and technologies (e.g. in-house emergency call system) into a continuous and gapless care arrangement. This aim figured less prominently in the accounts of the Dutch respondents. However, several sons and daughters also pointed out that if they had wanted to make things really easy for themselves, they would have sent their parent to residential care. As one of them explained, "Once you have moved your parents to a care home, you only have to visit them now and then."

Another related difference was found regarding the role of caring responsibilities as part of the German and Dutch families' decision to establish an LIMC arrangement. For German family carers, reducing their care burden was a much stronger motivation for employing an LIMC than for their Dutch counterparts. Whilst some German family carers relatively quickly acknowledged that they were overburdened, others only subsequently accepted "that there seemed to be a limit" to the care load they could manage. This was primarily the case in care constellations involving spouses. A sense of obligation together with the belief that the spouse is the most appropriate caregiver for the partner in need of care made some spouses hesitate to accept temporary relief from other care providers. This seemed to be more characteristic for the German than the Dutch respondents.

This difference may be explained by the German respondents actually bearing a higher care burden. German family carers seemed to be more frequently involved in daily care activities such as personal hygiene,

dressing or feeding. Dutch respondents, in contrast, were more likely to take on the roles of “care managers” (Degiuli 2010). When asked which care tasks they performed for their parent or partner, most of our Dutch respondents referred to the organisation of the care, administrative tasks (in particular managing their parent’s or partner’s LTC cash benefit) and the provision of emotional support. Our German respondents mentioned hands-on care and help more often.

That more German respondents reported feeling overburdened can at least partly be related to differences in the availability and use of LTC services in the two countries. Some German family carers employing an LIMC made additional use of care services such as day care centres, ambulant care services or volunteers. However, unlike in the Dutch case, the use of additional care services or household workers in German families was closely linked to their socio-economic resources. In the Netherlands, families are required to a lesser extent to draw on their own resources, due to the wider availability of publicly subsidised care services like household help and day care, which are administered by local authorities. These services are relatively easy to access, but they only suffice for older people with relatively light care needs. Once care recipients start to need around-the-clock care or supervision, they are referred from the Social Support Act to the LTC Act, which normally implies a move to a residential care home. In practice, it is impossible to organise 24/7 care at home with regular LTC service providers. Various Dutch family carers reported that they were disappointed to discover this.

Justification for Employing a Live-in Migrant Care Worker

Even though our respondents in both countries felt that LIMCs were the best available option to meet the care needs of their family members, this option was not per se an unquestioned alternative and it required justifications on various levels.

A Widespread Practice vs. Pioneering

A striking difference between the two countries was found with respect to the justifications given by respondents for using an LIMC arrangement. Various German family members reported that employing an LIMC was

recommended to them by health insurance workers or social assistants. In one case, professionals even provided them with brochures of placement agencies. Others pointed out that family members, friends or neighbours influenced their decision, and on occasion even convinced them to establish an LIMC arrangement. Altogether, the findings indicate that in Germany, it is a widely accepted social practice to employ an LIMC, regularly or irregularly. In other words, whilst German family carers would have to justify (to others and to themselves) bringing their dependent relatives to a residential care home, they do not feel the need to justify the decision for using an LIMC arrangement.

By contrast, various Dutch family carers reported that opting for an LIMC arrangement was by no means an obvious or uncontested choice. Only a few Dutch respondents knew other people who made use of an LIMC arrangement. In a sense, they were “pioneers” or “early adopters,” as the staff members of some placement agencies characterised their clients. As such, they are breaking new ground in the Dutch LTC system, and therefore, are faced with a different type of legitimation pressure than their German counterparts. Several Dutch respondents saw themselves as people who swam against the current, because they had acted against the advice of the family doctor or other care professionals to bring their parent or spouse to a nursing home. Their accounts show that in the Netherlands, residential care is still the “default option” for older people who need more or less constant supervision and help or care.

If the family doctor advises admission to nursing home, then it is very easy for the children to say: yes, let's just do that. Because if someone with knowledge and expertise tells you to do so, why not do that? Your father or mother may say: but I want to stay in my own home. - Yes, but that is impossible, you cannot stay here on your own, and we have a place in a nursing home now, let's just do that. And what does he say then, so as not to be a burden to his children: yes, then let's do it. But will he be happy then? C5, son of care recipient, high level of education (tertiary)

Moreover, several Dutch respondents reported disagreement within the family and the need to justify their decision to hire LIMCs, as other family members had a preference for “professional” carers. Although not frequently, they also received negative reactions from their social network where people put the legality or moral legitimacy of such an arrangement into question.

I told a colleague at work how I had arranged this – and this colleague had just brought her mother to a nursing home, she was in the same situation as me – and she almost lashed out at me: how could I do that, that was exploitation, social exploitation! C0, daughter of care recipient, high level of education (tertiary)

Apart from this difference, family carers in both countries justified their decision for employing an LIMC by the lack of alternatives. Other arrangements for providing around-the-clock care and supervision at home were seen as too complex to organise, too costly or simply not available. For instance, the very high costs for an around-the-clock care arrangement with regular home care providers were mentioned by German and Dutch family carers alike. A German respondent reported that for only an 8-hour shift, he received a cost estimate from a home care provider of about 4000 euro per month. Similarly, respondents in the Netherlands reported very high monthly costs (12,000–15,000 euro) exceeding most families' income.

Justifying Working Conditions

The LIMCs' working conditions are much more unfavourable than those of regular German or Dutch home care workers. In both countries, the LIMCs' pay is based on a 40- to 48-hour work week. It is challenging for family members and/or care recipients to develop specific arguments and practices to legitimise the fact that the carers are not paid for being on call many more hours. One strategy consists of downplaying the burden of presumed difficult working conditions. In this respect, we found arguments that justified their relatively low pay by arguing that LIMCs do not have to work all the time, that they get free board and lodging and that they earn much more than what they could earn in their country of origin.

Regarding the question of what should be considered as work and what as leisure time (e.g. having breakfast with the care recipient, being on call at night), family carers provided very similar justifications to the ones used by placement agencies. According to Schwiter et al. (2018), placement agencies construct discursive boundaries between working time and being present (not defined as work) to justify the incongruence between the contractually agreed 40 or 48 hours working week and the constant availability expected of the LIMC. Downplaying the LIMCs' work load was also a common justification, especially among German family

carers. These family carers often also claimed that the working conditions of their carers compared favourably with those of migrant carers in other families.

As far as the working conditions are concerned I think – it sounds almost presumptuous – but in principle it is a very nice house, it is generous. One can withdraw, one can also go out for an hour or two. In other situations, in other care contexts, this is impossible, right? PN13, daughter in law of care recipient, higher level education (tertiary)

Some German and Dutch family carers went beyond justifications and took action to improve their LIMCs' working conditions. Some of the Dutch family carers negotiated with the placement agency to obtain a higher pay for their LIMC or switched to another agency. One family carer terminated the contract with the placement agency and started to recruit and hire LIMCs himself. However, most family carers were not prepared to go that far, among other reasons, because the placement agency provided good quality care and/or continuity of care: "So, I disapprove of [the gap between what the carer and what the agency gets], but, you know, they offer good quality and I have a carer now."

In addition, in both countries, we found families hiring a second migrant care worker in intensive care situations. Care recipients with disturbed day and night rhythms and/or high mobility needs pose a challenge to a single migrant care worker and this may increase the risk of a premature termination of the arrangement. Through the employment of an additional migrant care worker, families lowered the individual care load and ensured the continuity of around-the-clock homebased care. A few families in the Netherlands were able to finance this option by applying for a new care needs assessment, resulting in a raise of the care recipient's cash benefit. In Germany, this option is only available to relatively few financially solvent families. Families with more limited financial opportunities who acknowledged the strains of the job also sought to reduce the migrant care workers' burden by creating a mix of informal and formal care providers. Accordingly, LIMC arrangements were often part of a larger care mix involving family carers, neighbours, outpatient care services, day care centres, community services, etc.

Type of Employment: Informal Employment vs. Employment Through an Agency

As described above, LIMCs are employed in different ways in the two countries. In Germany, to a large extent, the carers are hired informally. This is also reflected in our German sample, where migrant care workers were mostly hired on an informal basis. By contrast, in the Netherlands, LIMCs are mainly hired through placement agencies. The justifications given by the German and Dutch respondents for the mode of employment of their LIMCs were therefore correspondingly different.

German families employing an LIMC informally may feel compelled to legitimise their decision. Financial aspects played a role in this regard but perhaps not as one would expect. Whilst some mentioned that employing an LIMC directly or through a placement agency exceeded their financial possibilities, others argued that the LIMC preferred to be informally employed in order to receive a higher net income. Placement agencies were blamed for charging very high fees whilst only paying little to the migrant care workers: "They earn a lot of money at the expense of the migrant carers who do the work." By criticising the apparently unethical practices of placement agencies, family carers construct themselves as morally superior, giving their own informal practices a positive connotation. That many other families also employed an LIMC informally strengthened some respondents' belief that the state tolerated this practice to prevent the breakdown of the German LTC system: "I gave thought to it but so far it has gone well. Like in the case of hundred thousand others as well...And I say, the state tolerates it. Without it, care in old age would be impossible."

Although most Dutch family carers hired their LIMC through placement agencies, many of them were not confident about the legality of their LIMC arrangements. They did not know or understand the EU posting of workers' rules and doubted whether their placement agency complied with all relevant laws and regulations. In a few cases, these doubts were fuelled by negative reactions from the respondents' social network. The justifications of these family carers for why they continued to hire migrant carers were typically couched in terms of responsibility. They argued that they could not be held responsible for ensuring proper working conditions because they were only buyers of care services and their first

priority and responsibility was that their relatives received good care. In these respondents' view, the placement agencies have prime responsibility for the working conditions and the state should control the agencies. As one family carer said, "As the state has made a mess of the care system, they have a responsibility here as well." Another family carer told us about a conversation he had with the administrative agency that organises the LTC in his region:

I asked: does nobody look at how this company [placement agency] works? - No, nobody.
I asked: who should do this? - You have to do that. I said: I am not Sherlock Holmes, I cannot do that, that is not my job. I think that if the government grants this money, there should be a kind of inspecting body, but there is not. C1, son of care recipient, high level of education (tertiary)

In summary, family carers in both countries feel different needs to justify their making use of an LIMC arrangement. The norm of professional LTC in the Netherlands has a bearing on how Dutch family carers have to justify their decision to their social environment as well as to themselves. To justify the LIMCs' working conditions, they refer to the responsibility of the placement agencies and the state to ensure Dutch working standards. German family carers also refer to placement agencies and the state, although for different reasons. They refer to the apparently abusive practices of placement agencies and the state's failure to provide affordable quality care to justify why they employ their migrant carers informally.

Conclusion and Discussion

We started from the observation of the different scope and features of LIMC arrangements in Germany and the Netherlands. Whilst these arrangements are widely used in Germany, they are (still) a small-scale phenomenon in the Netherlands. We explained this difference by the different configurations of LTC regimes in the two countries. In Germany, social norms of family responsibility are reflected in the country's LTC policies that prioritise informal over institutional care. Accordingly, relatively low but unregulated cash-for-care benefits foster informal care arrangements and facilitate the employment of LIMCs. Germany's laissez-faire policy towards irregular employment of LIMCs in private households notably

contributes to this development. In addition, high co-payments and serious concerns about the quality of care provided make residential care homes neither an affordable nor a desired option for many German family carers and their relatives in need of care.

In the Netherlands, residential care is the default option in case of heavy care or supervision needs in old age, despite a recent policy trend towards deinstitutionalisation and deprofessionalisation. In fact, policy efforts to deprofessionalise LTC have not led to a substantial change in the country's professional LTC infrastructure. Dependent older people can still draw on a broad range of available and affordable LTC and home help services, enabling family carers to maintain their role as care managers rather than becoming providers of hands-on care. Although cash-for-care benefits are relatively high in the Netherlands, they are tightly regulated and supervised. Together with the availability and affordability of other options, this seems to discourage family carers from more widely opting for cash-for care benefits, as indicated by the very small proportion of older people receiving these payments. Moreover, it can be assumed that their tight regulation and supervision disincentivises the development of a black labour market for LIMC arrangements.

Our empirical analysis of interviews with primary family carers in the two countries has shown how the different LTC regimes in Germany and the Netherlands affected family decision-making. Although family carers in both countries explained the decision for an LIMC by their preference for a home-based care arrangement, they took their decision for different reasons. The decision of German family carers to employ an LIMC was primarily triggered by the aim to avoid moving the care recipient to a residential care home and to reduce their own care load. Moreover, by employing an LIMC, they did not challenge the social norm of family-based care in old age, in that the arrangement remained in the private sphere. At the same time, it offered a way to deal with the structural constraints inherent to Germany's LTC regime, which places a high responsibility on the family and consequently leads to the overburdening of (many) family carers. Additionally, due to the social norm of home-based LTC in old age and the widespread use of LIMC arrangements, German family carers felt little pressure to justify their decision for using this kind of care arrangement, including the employment of LIMCs on an irregular basis.

By contrast, in the Netherlands, the decision to employ an LIMC was linked much more to the care recipients' specific needs than to an overburdening of family carers and the rejection of institutional care. In this sense, LIMC arrangements represented an extended option of LTC in old age tailored to the individual needs and not an escape route from a structural dilemma as in the German case. However, due to the high acceptance of institutional care, the norm of professional LTC services and the novelty of LIMCs, Dutch family carers were more likely to have to justify their decision to their social environment as well as to themselves.

Another striking difference between Dutch and German family carers lies in their expectations towards public authorities in ensuring working conditions compliant to labour law. Whilst German family carers saw themselves as the main actors responsible for creating (in their view) decent working conditions, Dutch family carers referred to the responsibility of the placement agencies and public authorities to ensure Dutch working standards. When German family carers referred to placement agencies and public authorities, it was for a very different reason. They referred to the abusive practices of placement agencies and the state's failure to provide affordable quality care to justify why they employed their migrant carers informally. In sum, the Dutch and German LTC regimes impact differently the decision-making processes of families as well as on patterns of justification through a combination of policies and social norms and the related expectations towards care and care work in old age.

Several questions arise regarding the future development of the scope and configuration of LIMC arrangements in Germany and the Netherlands. Will the political *laissez-faire* attitude towards irregular employment of LIMCs in Germany continue? How sustainable is this approach in view of changes in the sending countries and a rapidly ageing population? As far as the first question is concerned, irregular LIMC arrangements are not an urgent issue on the political agenda in Germany. Policymakers are well aware that inspections and regularisation measures would increase the costs for employing an LIMC through fines and higher wages. Families not able to afford the additional costs would have to fall back on alternative care resources to fill the resulting care gap. An even stronger reliance on family carers and a growing demand for places in already understaffed residential care homes would be a probable scenario.

Public pressure on policymakers to relieve family carers' burden and improve the working conditions and care quality in residential care homes would presumably lead to unpopular policy reforms in order to broaden the income base of the LTC insurance. Briefly put, LIMC arrangements are cost-effective for the German government and relieve it from the necessity to develop solutions for the deficits in LTC provision for older people.

The recent increase of cash benefits in Germany has certainly brought some financial relief to LTC recipients and their families. However, several family carers interviewed reported requests for higher salaries from irregularly employed LIMCs during the last 2 years. Although the relationship between the two developments is not clear, macro-structural changes may influence the negotiations between private households and LIMCs. The request for higher salaries may also indicate an increasing shortage of labour supply and/or improved bargaining power of LIMCs. Indeed, the unemployment rate in Poland, the main source country of LIMCs in Germany, decreased considerably since the 2008–2012 global recession (Eurostat 2018). The relatively high average age of Polish LIMCs (Krawietz 2014) further suggests that the younger generation are not necessarily going to follow their mothers' and grandmothers' path. This trend has been confirmed by different managing directors of placement agencies who recruit their personnel increasingly from other Eastern European countries. They also reported difficulties to place LIMCs in households in areas with less developed infrastructures, especially in rural areas. Altogether, this indicates that there is no certainty about the sustainability of these arrangements as a fundamental pillar of the German LTC regime.

It is equally difficult to predict whether LIMC arrangements will become more widely used in the Netherlands. On the one hand, the shift in preferences from residential to home-based care and the impossibility of organising around-the-clock care at home with regular LTC services might well make LIMC arrangements a potentially interesting option for a growing number of families. Moreover, the relatively generous Dutch LTC cash benefits would make it an affordable option for a large number of families. Cash benefits were a late addition to the Dutch LTC system, and it is still much more common to make use of in-kind benefits. However, the accounts of the Dutch respondents indicate that the barriers to opting for cash benefits and LIMCs are lower if LIMCs can be hired

through placement agencies, which, in the perception of potential clients, are not that different from other private home care providers.

On the other hand, social and moral norms about how and by whom LTC for frail old people should be provided may be a more important barrier. Family carers in the Netherlands experience strong pressures to opt for residential care and “professional” carers when the care needs of their relatives increase. Moreover, to the extent that there is public or political debate about the use of LIMC arrangements, they tend to be seen as exploitative and as contributing to the displacement of Dutch care professionals rather than as a potential solution for deficits in the existing LTC system. Although the number of LIMC placement agencies in the Netherlands is only a fraction of that in Germany, Dutch parliamentarians have already asked critical questions about these agencies’ practices. Overall, it seems very unlikely that Dutch authorities would get away with a laissez-faire attitude towards large-scale informal employment of LIMCs like in Germany or, for that matter, tolerate irregular practices of LIMC placement agencies.

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Corresponding Author

Vincent Horn, Institute of Education, Johannes Gutenberg University Mainz, Jakob-Welder-Weg 12, 55128 Mainz, Germany. Email: hornv@uni-mainz.de

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Care facilities for Germans in Thailand and Poland: making old age care abroad legitimate

By *DÉSIRÉE BENDER** & *CORNELIA SCHWEPPE**

Abstract

This article looks at old age care facilities abroad that target people who live in Germany. Such facilities have been established in Southeast Asia (mainly Thailand) and in Eastern Europe (mainly Poland). Given that they challenge central guiding orientations for old age care in Germany, considerable criticisms are levelled at them, and their use is viewed with distinct scepticism. Nevertheless, some of these facilities succeed in sustaining considerable demand from Germany over quite a few years. In this article, we therefore ask what strategies and arguments they use to make them a legitimate option for people in Germany and to be established on the German market. Based on two case studies of an old age facility in Thailand and Poland, we will show how they skilfully position themselves as “better” options for residential care even though their strategies considerably vary and result in very different models of old age care. Drawing on neo-institutional organisation theories, we will show how these strategies are essential for the facilities’ emergence as new players in the care market for older people from Germany.

Keywords: international retirement migration, legitimation, long-term old age care, migration in old age, old age care, organisation theories, Poland, residential old age care, Thailand.

* *Désirée Bender & Cornelia Schweppe*, Institute of Education, Johannes Gutenberg University Mainz, Germany

Introduction

The provision of care for the rising numbers of old people with care needs in Germany, as in many other European countries, is subject to considerable criticism (Rothgang et al. 2012). Severe shortcomings in old age care, such as high costs, a lack of quality care, a precarious staff situation and a lack of at-home support, have been identified by many studies and pointed out in policy debates and by relatives and people who need care in old age (see below). In response, cross-border developments and transnational care arrangements have emerged over the last few years. More specifically, the employment of migrant care workers in private households has become a widespread phenomenon in many Southern and Central European countries. Germany is no exception (Böcker et al. 2017). With the number of migrant care workers estimated at up to 300,000 (Arend 2017), they have also become a significant pillar of the German old age care system.

In recent years, another border-crossing development can be observed. Instead of moving carers in, as with the migrant care workers, this phenomenon can be called a “moving of care out.” It manifests through the establishment of old age care facilities abroad, catering to specific nationalities or linguistic communities. Toyota and colleagues pointed to this development for older Japanese and the establishment of a broad spectrum of care facilities targeting them, particularly in Malaysia (Toyota & Thang 2017; Toyota & Xiang 2012). In the last decade, this development can also be observed for people from Germany. Most of these facilities have been established in Southeast Asia (mainly Thailand) and Eastern Europe (mainly Poland) (Bender et al. 2018; Großmann & Schweppe 2018; Horn et al. 2016).¹

Old age care facilities abroad can be described not only as a relatively new actor in the transnational old age care market (drawing on Schwiter et al. 2014), but also as a new type of old age care facility (Bender et al. 2017) because the care of old people is displaced abroad, requiring old people to migrate across borders for the purpose of care. These challenges

¹ According to the Internet platform “Wohnen im Alter” (“living-in-old-age”; www.wohnen-im-alter.de), which is one of the main internet platforms in Germany for care options in old age in Germany and abroad, old age care facilities in the Philippines, Bosnia and Herzegovina, Bulgaria, Croatia, Rumania, Slovakia, Slovenia and Czech Republic are mentioned. To our knowledge, there are no studies on old care facilities in these countries.

the principle of “ageing in place,” which is one of the main professional and public guiding orientations for old age care in Germany (Engelmann et al. 2013). Many critical media reports (Hahn 2012; Posener 2014; Prantl 2012), along with opinion polls (Konpress and Emnid 2013) registering distinct scepticism towards care abroad, indicate that these facilities are by no means generally accepted or considered legitimate as yet. Nevertheless, a few facilities have succeeded in upholding considerable demand in Germany over several years. In this article, we therefore ask about the strategies and arguments used by these facilities when presenting themselves so that, despite the widespread criticism, they are taken up by people from Germany and become established in the German market.

Questions about how newer border-crossing old age care organisations establish themselves in the old age care market have been little researched so far (Schwiter et al. 2014, 2018). Some references can be found in studies dealing with placement agencies for migrant care workers (ibid.; Krawietz 2014). Despite criticism and scepticism, these have become established in great numbers due to a growing demand for migrant care workers in private households in Germany. According to a study by the German consumer organisation and foundation Stiftung Warentest (2017), more than 250 placement agencies of live-in migrant care workers are active in the country. In studying how these agencies became established in the market, a key finding shows that they skilfully pick up on relevant criticisms of old age care in Germany and present themselves as qualitatively superior to the offers of care available (Schwiter et al. 2014).

The present article is based on the research project “Moving Old Age Care Abroad – New Facets of Ageing and Care Arrangements,” which examines old age care facilities in Thailand and Poland that target and serve people from Germany.² Based on two case studies of old age care facilities in Thailand and Poland that have succeeded in maintaining themselves over a longer time period, we analyse how they project themselves to be taken up as an alternative to the care options existing in Germany.

We begin by explaining the main strands of criticism of old age care facilities in Germany as well as the criticism of using care facilities abroad.

² The facilities in Thailand also target and serve people from other German-speaking countries (mainly Switzerland).

Both critiques are important, as they form the background against which the old age care facilities abroad develop strategies to establish themselves in the German market. We also elaborate on the circumstances and reasons why these facilities especially have emerged in Thailand and Poland. We then proceed to the case studies of the two care facilities. Although these facilities are very different, our comparison shows some noticeable similarities. To conclude we explain the significance of the strategies the facilities use for their establishment in the care market in Germany.

Methodological Approach

The article draws on data collected in the research project “Moving Old Age Care Abroad – New Facets of Ageing and Care Arrangements.” The project focuses on the analysis of the contexts in which these facilities emerge, the motivations of the (migrating) residents and/or their relatives, the living conditions in these facilities, and the strategies and arguments developed by the facilities to position themselves as a favourable option for old age care of people from Germany. The following article focuses on the last aspect. The study was conducted between 2014 and 2018 during seven field trips. The empirical data from Thailand were collected in the course of six 2- or 3-week field trips to the facilities between 2014 and 2018, and from Poland in the course of two 3-week field trips in 2016. Each field trip to Thailand and Poland was conducted by two researchers. Due to the different locations of the facilities, research sites included rural areas in the Northeast, cities in North and Central Thailand, as well as islands. The field trips to Poland were conducted in the Southern and Southwest part of the country.³ The study uses an ethnographic approach and includes participatory observation of everyday life in the facilities; qualitative guided interviews with operators, managers, staff, relatives and residents; and the analysis of the facilities’ websites.

Data collection was conducted in seven facilities in Thailand. The selection of these facilities was first based on an Internet search in which we found 19 facilities. After exploring the websites to gain an initial

³ Concrete locations are not mentioned, for reasons of anonymity.

insight into the character of these facilities, we chose 11 to contact them. We selected them on the basis of differences in costs, size, location (rural-urban), resident composition and degrees of care required by their residents. One of these facilities declined its consent to our research, one was no longer operational and from one we did not get a response despite various attempts. The remaining facilities we visited on site. During our fieldwork we discarded another facility due to its recent opening and lack of residents. In Poland we included four facilities in the sample. The sampling strategy was also first based on an Internet search in which we found 32 facilities that offered their service (also) to people from Germany. In contrast to Thailand we contacted all of these facilities because it was unclear from their websites to what extent they actually managed to attract people from Germany. Ten facilities were unreachable despite repeated attempts by e-mail and phone. Thirteen facilities were excluded from the sample because six facilities were not operational, four had not (yet) attracted people from Germany and three because of Polish-German/English language barriers. The remaining nine facilities we visited on site. However, we found out that only four of them actually had German residents. The other five facilities had not been able to recruit residents from Germany (Großmann & Schweppe 2018).

The results we present in this article are informed by the analysis of all of the empirical material collected. However, we especially rely on the data from two facilities (i.e. one in Thailand and one in Poland). Of particular relevance are the analyses of the facilities websites and the qualitative guided interviews we conducted with key actors involved in the running of these facilities, particularly the facility operator in the Thai facility and the care manager of the facility in Poland. Both actors were interviewed twice. To conduct the interviews, we started with a narration-generating stimulus stating our interests in care facilities targeted at people from Germany. We explained that we would like to learn about the development of the respective facility, everyday life and care delivery. Depending on the respective information given, we added questions about the problems and challenges they encountered, as well as about the qualification and number of staff, and the residents' biographical backgrounds. We also asked about their experiences with regard to the decision-making process of recruiting a person from Germany in the respective facility,

and the way they countered possible objections. Data analysis followed an inductive exploratory approach which was guided by grounded theory methodology (Strauss & Corbin 1996). We began with the analysis of the interviews. They were coded and analysed line by line to identify potential key themes. Following the constant comparative method (Strauss & Corbin 1996), we continuously compared the emerging themes with one other and explored theoretical ideas and concepts. This way ideas and concepts were refined, while new ones were also generated. We then analysed the websites, following the same analytical procedure as for the interviews. The findings from the websites and the interview analysis were then related to each other to further deepen our analysis and to specify the emerging arguments in their self-presentation and the theoretical categories (Corbin & Strauss 2008).

The facilities chosen to illustrate our results were selected because both had achieved sustained take-up by German-speaking people over a longer period of time and were either expanding or had deliberately decided against expansion for reasons related to the facility concept (more on this is given below). Specifically, the facility in Poland was chosen because it was the only one that had successfully managed to establish itself for people from Germany in Poland during the study period (Großmann & Schweppe 2018). It opened with 40 places and thereafter expanded to a capacity of 74 places due to high demand. The facility in Thailand is one of the first facilities there for German-speaking people. Since opening, it has attracted notably high demand, and generally fills any vacant places quickly. In one additional respect it is especially significant: our study reveals that the strategies it has developed to create acceptance in the German market are being adopted by other facilities in Thailand. Even if the organisational models vary in other facilities, we found that their arguments to gain acceptance by people from Germany were adopted to a large extent from this facility (Bender 2015).

Criticism of Old Age Homes in Germany

An important background to the emergence of old age care facilities abroad, as well as their positioning as a favourable care option for people from Germany, consists in criticism of residential old age care in Germany.

A central problem is its *high cost*. The considerable cost burden is reflected in high co-payments which amounted to an average of 1.831 Euro monthly in 2018 (PKV 2018). It is also reflected in the large number of people who are unable to cover the costs of old age care facilities and require supplemental financial support from the state. In 2015, out of 450,674 recipients who received “Hilfe zur Pflege” [supplemental public care assistance] approximately 72% lived in old age care facilities (Statistisches Bundesamt 2015). Therefore, it is not surprising that almost 60% of the German population considers that residential old age care is barely affordable or not affordable at all (Eurobarometer 2007).

Severe criticism also points at the *quality of care* provided. A key focus of this criticism is the orientation of care to organisational rationalities at the expense of an orientation to the individuality of people needing care and their specific lifeworlds. This often goes along with the lack of their participation in the decision-making processes of how they wish to be cared for. Only rarely can they decide on their own daily routine and activities (Schneekloth & Wahl 2009).

The dominance of the medical paradigm in old age residential care is another focus of criticism. When the long-term care insurance was introduced in Germany in 1995, the medical paradigm became firmly anchored in billable care (Jansen & Klie 1999; Schweppe 2005, 2012). Due to the legal regulations, costs of services can normally only be billed if they relate to bodily or hygienic aspects. This often ignores, or is at the expense of, the social and emotional aspects in care. In addition, strict stipulations for the services that can be billed, according to which activities such as feeding or bathing are calculated on a per-minute basis, add weight to the critique of an increasingly visible standardisation of care (Behr 2015).

Another key problem is the highly *precarious personnel situation*. This is characterised by a considerable shortage of care workers, which is projected at almost half a million by the year 2030 (Horn et al. 2016; Rothgang et al. 2012). The precarious personnel situation is also expressed in qualification deficits, high personnel fluctuation, high workload and high case numbers (Schneekloth & Wahl 2009). Accordingly, the care work is fast paced, giving little latitude to engage with the old people’s individual needs.

Furthermore, *violence* is one of the central shortcomings of residential old age care in Germany. This includes physical and mental abuse,

neglect and avoidable restrictions of freedom and autonomy of action and decision-making (Görge 2017), for example, through the (medically unjustified) use of sedatives to immobilise residents labelled as “aggressive” or “difficult” (Grassberger & Püschel 2013: 250).

The Emergence of Old Age Care Facilities for People from Germany in Poland and Thailand

Even though these shortcomings and criticism play an important role in the emergence of old age care facilities abroad for people from Germany (Horn et al. 2016), so far there are no systematic studies on why the facilities emerged especially in Thailand and Poland. The considerable lower wage and living costs in both countries certainly provide favourable conditions to develop lower cost care alternatives compared to the high costs in Germany, and thereby address one of the main challenges of residential care in Germany. Also, the long and multilayered relations between both countries and Germany can be considered as favourable conditions for their emergence.

In the case of Poland, historical developments and interdependencies since the Second World War, along with extensive migration processes of people from Poland to Germany, are especially relevant (Loew 2017).

In addition, people from Poland play a significant role in the above-mentioned employment of migrant care workers in private households. Even though there are no exact numbers, people from Poland play a significant role in the transnational care market that has developed between Poland and Germany. The following quote from a German news portal illustrates this well: “If nobody knows anymore (how to care for their older family members, added by the authors), you’re guaranteed to be told: ‘Well, go and get yourself a Pole. The Poles are the most important care stopgap of the nation’” (Maybaum 2017, translated by the authors).

Besides these favourable conditions, it is not clear whether there are other concrete conditions leading to the establishment of the facilities in Poland. Overall, the high costs of old age residential care in Germany seem to be of high relevance for their emergence. The lower care costs in the facilities in Poland as compared to Germany play a significant role in

our data as well as in the media, and are presented as a prominent reason for their attractiveness.⁴ This points out that the facilities in Poland were envisioned as a response to a demand by people from Germany, and target a potential market by addressing a sensitive old age care problem in Germany. In addition to the low wage and living costs, the possibility of transferring benefits from the German long-term care insurance to Poland plays a further role in reducing out-of-pocket costs compared to Germany.⁵

Some interviews with the facility managers in Poland also indicate that the high number of people from Poland in Germany played a role in the establishment of the facilities, as it was assumed that the facilities in Poland would also offer an attractive option for care in old age of this target group. However, our data show that the facilities do not attract this target group; so far, people from Poland who live in Germany hardly make use of them.

The relation between Germany and Thailand is also marked by diverse cultural, economic and political ties (Stoffers 2014) and by a steady tourism stream of Germans to Thailand. Furthermore, Thailand has become a prominent destination for retirement migration from Germany (Jaisuekun 2017; Jaisuekun & Sunanta 2016; Jöstl & Wieser 2011). In addition, our study indicates that the facility, which we present below and which was the first one established in Thailand, had a significant impact on the establishment of further facilities. Our data show that facilities created later adopt some of the arguments formulated originally by this facility for why care abroad and especially in Thailand presents a promising alternative to old age care in Germany (Bender 2015). In addition, the biographies of the founders of the facilities provided favourable conditions for the emergence of the facilities in Thailand. All founders are Swiss or German. Biographically, they were connected to Thailand for many years, for example, through work experiences in Thailand or marriage

⁴ This raises a potential question for future research, namely, through which processes was the knowledge about the high residential care costs as a main care problem in Germany made available in Poland and whether the above-mentioned transnational care market between Germany and Poland contributed to it.

⁵ Benefits from the German long-term care insurance can only be transferred within the European Union.

to a partner from Thailand. This biographical entanglement provided an important knowledge base and sometimes material resources, such as the inheritance of land in Thailand in the case of Thai-German couples to set up a facility in Thailand, which often corresponded to their wish to permanently relocate their place of living and work to Thailand. In Poland, we could not observe similar processes.

Even though one might expect that the widespread retirement migration from Germany to Thailand had an impact on the emergence of the facilities, our study shows that hardly any of the residents were already living in Thailand before moving into the facilities. For the large majority of the residents, the choice of the particular facility equates therefore to a decision to migrate to Thailand (Bender et al. 2018).

Criticism in Germany of Old Age Care Facilities Abroad

Although the old age care facilities abroad promote themselves as far better care options than those in Germany, while at the same time being far more reasonably priced, opinion polls reveal high levels of scepticism about or rejection of care abroad. A representative survey (Konpress and Emnid 2013) showed that 85% of Germans reject the option of placing a relative in need of care in an old age care facility abroad, compared to 23% of Germans who generally reject placing a relative in need of care in an old age care facility. Only for 3% of Germans the option of old age care abroad is an unqualified option, compared with 17% of Germans with regard to a placement in an old age care facility in general. The main reasons for rejecting the option of an old age care facility abroad are geographical distance and the desire to keep their relatives geographically close (89% of respondents), the anticipation of language barriers and problems in communicating (72%), the anticipation of challenges in dealing with a different culture (71%) and fears that medical standards are not as high as in Germany (56%). The same scepticism is voiced in the German media. Resorting to care abroad is often described by terms like “deportation” (Weingärtner 2012), dumping, inhumanity or a “forced disposal of the elderly” (Prantl 2012; translation by the authors).

In accordance with this criticism, it can also be empirically observed that – contrary to the discourse about the mass displacement of old age care abroad, propagated with the media catchword of “Granny

export" (Kresge 2013) – the take-up of such care is a rather small-scale phenomenon, especially in Poland (Großmann & Schweppe 2018).

Care facilities abroad challenge the principle of "ageing in place," which counts as one of the pivotal orientations of old age care in Germany. In normative discussions about "good care" in Germany, remaining in familiar surroundings is considered an important aspect. The same applies to residential care: a residential placement should be close to where a person previously lived (Mischke et al. 2015). Thus, the principle of "ageing in place" locates "good care" for older people within the local and – in the broadest sense – national context. The significance of this principle is also reflected in the previously mentioned reasons for rejecting placement in a residential care facility abroad. The unease about care facilities abroad is therefore twofold: they decouple residential care from familiar surroundings and the national context, and they require old people to migrate abroad for the purpose of care.

Against this background, old age care facilities abroad are not directly compatible with the orientations that define "desirable care" in Germany. Therefore, the question emerges how some of them succeeded in establishing themselves nonetheless, and how do they maintain themselves over several years in the German market? To answer these questions, in the following we will present the two old age care facilities in Thailand and in Poland.

The Facility in Thailand: A "Loving and Respectful" One-to-One 24-Hour Care Arrangement

The facility in Thailand is located in a village in the immediate vicinity of a mid-sized city in Thailand. It has a Thai name. It provides a space for 13 persons. It is specifically targeted at people from German-speaking countries, who either have dementia or are in need of permanent care for other reasons. It was founded and is run by a Germanophone European. The caregiving staff are recruited from Thailand. Despite quite high demand, the facility does not envisage an expansion (more on this below).

One of the facility's central characteristics is its 24-hour care provision. This is organised by allocating three Thai caregivers to each of the persons in need of care. These three carers work 8-hour shifts in rotation and are only responsible for their allocated resident, so that a constant

one-to-one care is available. In allocating the carers, the facility manager pays attention to their suitability to the individual needs and competences of the given residents. Regarding the language skills of the residents, the facility manager says, for example:

We now have three residents, they suffer from dementia (.) All three of them (.) have travelled quite a bit (.) and can speak good English, even now, despite their dementia. So for them, it really makes sense to (.) have carers who can speak English too.

The high staff ratio is also emphasised as important for individual care as it would allow for the delivery of care according to each residents' wishes, needs and special characteristics, the individual structuring of the daily activities, and to ensure individual care also during the night. On the facility's website it is explained that during the night, one of the resident's three carers lies beside the resident's bed and therefore the carer could respond immediately if the resident wakes up and requires support. It is also argued on the website that this individual care arrangement would eliminate the need to use restrictive measures such as physical restraints, the use of bed rails or sedating medication, which are present in old age care facilities in Germany (Newerla 2012).

The size of the facility is also considered beneficial and substantive to providing every resident with individual attention. The facility manager considers the small size as a crucial pillar of the facility and its care concept:

That's why I'm not really in favour of those ideas, of bigger projects. Of course, I was confronted with this question early on. I had investors who wanted to scale things up right away. But then it's the same as in Europe - then you're no better off than in Europe.

In this care arrangement tailored to the individuality of each resident, the importance of the relationship between the carers and the residents is emphasised. As the facility manager explains, the development of a positive relationship between the carers and the residents is especially significant to attend to the residents' specific needs.

In this regard, the specific quality ascribed to the Thai staff is of special importance and is marked as a particular hallmark of the facility. In this regard, the facility draws upon a widespread narrative about old people

in Thai society according to which people in old age are treated with high respect, love and affection (Leifeld 2002; Thiesen n.d.). This argument is continuously reiterated by the facility manager and prominently displayed on the facility's web page, indicating that this special treatment would also be reflected in the facility's care work. It is also pointed out that caring for older people is considered an especially meaningful and socially recognised task in Thailand, resulting in distinct motivations to care for them.

The warmth, tenderness and physical closeness in caregiving, highlighted by the facility as a special seal of its care quality, are presented as characteristics that particularly address the needs of people with dementia. The arguments developed by the facility in this regard are that, along with the decline of verbal communication as the disease progresses, people with dementia would increasingly look for bodily contact. Likewise, Thai people's attitude towards older people, which is characterised by "great respect and deference," is also presented as impacting positively on people with dementia as it would strengthen mutual trust and the self-esteem of people with dementia. It is thus emphasised that the traits ascribed to the Thai caregivers are almost perfectly matched to the condition of dementia. In this way, Thai people are constructed as especially qualified carers for people with dementia, and the facility residents as ideally cared for addressees of the facility (Bender 2015).

In contrast to the high significance attached to physically close interaction with the residents, the facility relativises the significance of verbal communication. This argumentation comes into play against the background that the Thai staff generally speak little or no German. Also for the relativisation of verbal communication, the disease of dementia becomes relevant. The decline in verbal communication abilities of people with dementia is pointed out, along with the need to seek other forms of communication which, it is claimed, often expose entirely new resources and potentials of the residents. In addition, the facility argues that the avoidance of verbal communication can also result in positive and less conflict-prone relationships between residents and carers. In this regard, the facility refers to not further specified experiences that when family members or other carers communicated with dementia patients in the same language, in the event that the old person was dissatisfied or distressed,

the carers often felt a need to justify themselves which then could lead to mutual blaming or accusations. Precisely this could be avoided through non-verbal or other forms of communication.

The geographical distance from the country of origin is also relativised against the background of dementia. The facility manager recounted various situations in which the facility's residents went out walking in the neighbourhood of the facility with their carers and "recognised" houses of their previous environment in Europe. Implicitly, these narrations relativise the importance of specific places for feelings of familiarity for people with dementia because they rediscover previously familiar realities in other locations. This can be interpreted as an attempt to address the above-mentioned scepticism towards old age care abroad due to the geographical distance from the place of origin and its associated fears of potential alienation. According to the experiences recounted by the facility manager, geographical distance with regard to feelings of familiarity is rather unproblematic for residents with dementia.

In addition, the facility points out on its website that Thailand's warmer climate is another advantage for the residents. It is argued that, due to the warmer climate, some of the medication is dispensable and the residents would suffer less from colds and influenza.

With regard to costs, the facility web page states that cost details cannot be given in advance as these are always calculated individually to tailor the care to the specific resident. However, the website claims that the costs are generally less than half the cost of similar care in Germany.

The Facility in Poland: German Standards at Low Costs⁶

The facility in Poland opened in 2013. It is located on the outskirts of a small city. The facility opened with a capacity for 40 residents and expanded to 74 places due to high demand. It is run by a general manager and a care manager, who both come from Germany. The general manager, a business consultant, lives in Germany and is the primary contact for persons who are considering the facility as a caregiving option. The care manager lives in Poland and is responsible for the daily running of the facility. The caregiving staff are recruited from Poland.

⁶ This part of the paper is based on Großmann and Schweppe (2018).

On the website, the facility presents itself as an offer that promises “high standards of care at an affordable price.” The prices of the facility are far below of those in Germany. In 2013, the monthly average cost of a place in a residential old age care facility for persons with medium care needs amounted to €2530 in Germany (Böcker et al. 2017), while in the facility in Poland the cost was between €1400 per month for a single occupancy room and €1300 for a double room.

The facility has a German name, which matches with its many other references to Germany. As can be seen, these references run like a common thread throughout the facility’s self-presentation. For instance, in the pricing details right on the very first page of its website, it is mentioned that the costs include access to German radio and television stations. In another example, the care manager explained to us that the facility is equipped with German tableware so that the residents can feel “at home.”

Great value is also placed on the German language. In addition to the website presenting the facility as a “German-speaking old age home in Poland,” the carers’ good German language skills are repeatedly pointed out in the interview with the care manager as well as on the website. A German-language 24-hour crisis helpline and German church service are also noted.

Reference is made to Germany also with regard to care. Both in the interview and on the website, it is underlined that the care is comparable with “German standards.” When the care manager was asked what she meant by German standards, she pointed out that the facility “really is run like in Germany.” In this regard, care documentation is emphasised in the interview as well as on the website, and singled out as a special seal of the quality of care provided as it would ensure individual care provision and the continuity of care. In addition, the care manager explains why care documentation is of particular importance to the facility, when she says:

(S)hould a resident apply for a higher level of care benefits from the German old age care insurance provider, the corresponding German assessment organization (German Medical Service) would conduct an on-site health assessment of this resident, and the facility’s care documentation plays a crucial role in the decision-making process.

The second “German standard” that the care manager points out relates to the concept of activating care. In old age care in Germany, this concept

is of high significance, and legally anchored (German Social Security Act XI, Section 11 Para. 1). According to the law, old age care facilities need to provide "humane and activating care with due regard for human dignity."

As a seal of care quality, the care manager also highlights the staff's good professional qualifications. She argues that their qualifications are as good as in Germany, and maybe even better. She bases her argument on the fact that the facility only hires staff with professional training, and for nurses the professional training in Poland exceeds the one in Germany with 2 years.

Although the facility repeatedly emphasises the alignment of its orientation to old age care with Germany, it also reassures that it does not reproduces the shortcomings of care in Germany. In this regard, the far better staffing level is considered of crucial importance. The care manager says:

In Germany the staff ratio is one to ten or one to 15. That's abysmal and off the charts. And here it is one to five or one to six. That's a big difference.

Care workers in Germany are permanently rushed, she says, and can barely provide appropriate and good quality care. In contrast, her facility can provide a staff ratio of one carer to five or six residents. This makes a considerable difference to the care that is provided by her facility compared to Germany. The "very good staff ratio" allows staff "just to have time." "Having time" is considered a particular seal of quality for this facility. The care manager explains that this allows the staff to offer individual attention to each resident and to treat them with "love" and "affection." As evidence of how significant this is, she mentions the improved health status of many of the facility's residents and the emergence of new energy for life. She also points to the reduction of sedatives, and argues that this is the result of the quality of care that her facility provides. She mentions the example of one resident who arrived in the facility from Germany, "stuffed with medications" and in a bed-ridden state. Thanks to the reduction of "tranquillisers" that the conditions in her facility made possible, the resident regained mobility and was able to use a wheeled walker. Her previously aggressive behaviour had also reduced markedly.

Comparison of the Facilities

Despite the considerable differences between the facilities, a comparison brings to light notable commonalities. These are evident in the themes that are taken up, even though they are dealt with differently.

Language Differences

Both facilities pick up on language differences between Germany and Poland and Germany and Thailand, respectively. The care facility in Poland attaches importance to its care staff's knowledge of the German language and considers its German language skills as a particular hallmark of the quality of care it offers. The Polish language goes unmentioned. The facility in Thailand deals with the linguistic difference in another way. On the one hand, the ability of caregivers and residents to communicate verbally is considered significant, provided that the residents are still capable of it. However, the "mother tongue" is not necessarily deemed important to verbal communication; the residents and the carers may also fall back on a common foreign language (in this case, English). On the other hand, the significance of verbal communication is relativised. Based on the assumption that the avoidance of verbal communication may result in positive and less conflict-prone relationships between residents and carers, non-verbal guidance of residents with dementia through difficult situations is said to work better. The personnel's lack of German language skills is turned into a resource (Bender 2015). As different as the strategies of the two facilities are, both are aimed at relativising the significance of language differences between the care staff and the residents.

Geographical Distances

Both facilities pick up on and deal with fears relating to geographical distances or alienation by cultural differences, which in Germany are associated with the use of care facilities abroad. Similar to the language differences, arguments are developed in both facilities to counteract these fears. The facility in Poland follows its strategy of dealing with differences by alignment with Germany. Specific objects or materialities like

German tableware and the German language are used to convey a sense of familiarity, home, continuity and habitude to the residents. The Thai facility, on the contrary, uses the disease of dementia to point out that familiarity can be identified by the residents in the surroundings of the Thai facility. By implication, the sense of familiarity as it is often understood in association with specific places, spaces, and familiar materialities ceases to exist because of the disease. Rather, it can be rediscovered in the reality of Thailand, without Thailand as such taking on any particular significance.

The Quality of the Personnel

The qualifications of the care staff are also an aspect taken up by both facilities. Staff qualifications are implicitly or explicitly conceptualised as better, or at least equivalent when compared to Germany. In the Thai facility, the resources of Thai culture – which are naturalistically ascribed to every Thai (and hence every Thai caregiver) – are emphasised and interpreted positively. The Thai culture is interpreted as valuable, and as a significant resource for the care arrangement within the care facility in Thailand. In relation to its offer, the Thai facility constructs this resource as more suited to the needs of people with dementia than could be managed in the German-speaking context. The care in the facility in Thailand, according to its underlying but not explicit argumentation, is better than in Germany for cultural reasons. In this respect, it also positions itself in relation to medically oriented care. It is not medicine that is called for but emotionality, physical closeness, and dignity.

The facility in Poland, in contrast, relies on professionalisation, as in Germany, and argues that the professional qualifications of its staff are at least comparable if not superior with those in Germany. This way, feared quality differences due to a lower level of training may be counteracted.

The Quantity of Personnel

In both facilities, the (very) much better staff ratio in comparison to Germany is held up as a special seal of quality. Due to the better staff ratio, in both cases the care arrangement is presented as qualitatively superior than in Germany. They can offer care arrangements which exceed the

standards of residential old age care in Germany and address its criticism of scarce time and personnel resources – and, beyond that, at far lower prices than in Germany. The decisive reason why both facilities can dispose of such organisational realities at affordable prices is grounded in the very sizeable cost-of-living and wage-cost disparities that exist between Germany and Thailand and/or Poland.

Closely linked to the higher staff ratio is the use of medications. Both facilities point out that their higher staff ratio and the ensuing higher time resources allow them to dispense with unnecessary sedatives and instead to respond to individual needs such as an urge for physical activity. Hereby, they implicitly take up and respond to the widespread and criticised practice in Germany of “immobilization” by medication (Pfleger-Report 2017).

Making Old Age Care Abroad Legitimate

Looking at the arguments used by the facilities to position themselves and the care concepts the facilities project, what is their significance for take-up of their provision by people from Germany?

To explore their significance, neo-institutional organisation theories prove to be insightful. These theories are based on an understanding that organisations cannot be described as self-contained structures independent of social influences. Instead, the social environment is conceptualised “as a crucial influencing factor which penetrates the boundaries of the organization, establishes itself within it, and even exerts a formative influence on its shape and its operative scope” (Koch & Schemmann 2009: 22, quoted in Krawietz 2010: 252, translation by the authors). Accordingly, these theories argue that organisations need more than just material resources and task-related information to survive and point out the significance of establishing an accordance with socially shared values, normative expectations, and hence general rules and laws, to acquire legitimacy (Walgenbach & Meyer 2008). Legitimacy is viewed as the decisive criterion for the survival of organisations (Walgenbach & Meyer 2008). It is defined by Suchman (1995) as follows: “Legitimacy is a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions” (574). Once an organisation has legitimacy, it can

build on the support of other important actors. This support is crucial to the organisation's survival. Legitimacy is always linked to a certain social field and/or a particular reference group. This reference group is the "legitimatory resonance space of institutions" (Rehberg 1995, cited from Walgenbach & Meyer 2008: 65; translation by the authors) and the social instance of control which confers legitimacy on the organisation. An organisation is deemed to be legitimate when it fulfils this group's expectations (Walgenbach & Meyer 2008).

The substantial criticism and scepticism in Germany towards old age care abroad, and particularly the fact that the facilities do not directly align with the socially shared values and normative expectations inherent in the prominent guiding principle of ageing in place, indicate that opting for an old age care facility abroad does not immediately appear as something that "is the right thing to do" (Suchman 1995: 579) for potential users in Germany. If the facilities want to secure their existence on the basis of take up by people from Germany, they face the challenge of presenting old age care abroad as a legitimate option for them by establishing compatibility with socially shared values and normative expectations.

How this is done is evidenced in the analysis of the two facilities. A central element for both facilities is constituted by their explicit or implicit references to the structures, practices and public discourses of residential old age care in Germany. This encompasses both the criticism of old age residential care in Germany and criticisms of care facilities for Germans abroad. It is precisely in terms of the themes mentioned above – language differences, geographical distances, as well as the quality and quantity of care personnel – that these criticisms are taken up.

The two facilities tackle these themes in different ways. The facility in Poland projects itself as a facility which, although located in Poland, is not to be understood as a "Polish" facility for people from Germany, but rather as a "German" facility in Poland (Großmann & Schweppe 2018). It follows a concept that not only aims to align with "German culture" as much as possible, but it orientates its care concept to Germany, too. According to its arguments, the availability of more personnel makes it possible to offer an old age care facility where the German care concepts, which in principle are considered to be good, can actually be realised in their entirety. Ultimately, its motto is "Just like in Germany – only better"

(Großmann & Schweppe 2018); it thus positions itself as a qualitatively superior old age care facility in comparison to Germany.

In contrast, the facility in Thailand projects itself as a highly staff-intensive, individualised old age care facility, and by ascribing Thailand's specific cultural resources with regard to older people and old age care, it is presented as a facility in which the residents are treated with dignity, emotionality and physical closeness, which particularly fits the specific needs of people with dementia. In this case, very little of the reality of old age care in Germany is transferred to the facility. At the same time, all of the significant points referencing the criticisms of residential care in Germany are discursively integrated and addressed to justify and transform the care reality into a different and better version of care – without ever letting this comparison become explicit.

As much as the self-presentations of the facilities differ, their common strategy is to project themselves as a better care option in comparison to residential care in Germany. In doing so, they draw on ideas of "good care" within Germany, which are the basis for the criticisms of residential care pointed out before. Simultaneously, the facilities attempt to minimise the scepticism about or the rejection of care facilities abroad which is mainly caused by the irritation of the principle of ageing in place as a main principle of old age care in Germany. In the case of the facility in Thailand, this is done by challenging the underlying assumption of this principle. In this regard, the significance of specific places for feelings of familiarity and the significance of verbal communication or communication in the mother tongue in the context of dementia are relativised. In the case of the facility in Poland, differences and feared experiences of alienation due to the different national context are countered by equipping the facility with materialities from Germany and by highlighting the staff's German language skills.

Seen in this way, the self-presentations can be understood as legitimisation strategies aimed at establishing an "accordance with socially constructed systems of norms, values, beliefs or definitions" (Suchman 1995: 574) with regard to conception of "good care" in old age in Germany. In these legitimisation strategies, (discursive) knowledge about the respective national contexts with regard to old age care, as well as the concrete availability of resources in the respective countries, becomes so interlinked that the space in which the facility is located and the resonance space in

Germany addressed by the facilities merge with one another. The facilities' legitimisation strategies can be called transnational in both cases, in that they deliberately interlink resources from the different countries involved, both on the discursive knowledge level and on the level of concrete materialities, thereby bringing into being something new: legitimate care facilities for people from Germany abroad, within which (borrowing the words of Hoch & Schemmann) border-crossing interlinkages establish themselves and exert a formative influence on their shape and their operative scope (Koch & Schemmann 2009, quoted in Krawietz 2010: 252). In this regard, our study adds a new facet to the conceptualisation of old age care facilities for Germans abroad as transnational organisations (Bender et al. 2017, 2018).

The strategies for establishing this legitimacy and its connectivity to the German market differ, and must differ, because each country has different resources that can be utilised to fruitful effect for the German-speaking resonance space. For example, the 1:1 care arrangement in Thailand can only be offered because of the considerable wage and cost-of-living disparities with Germany. This disparity is much smaller in Poland, where a 1:1 care arrangement would entail costs that would hardly be a viable option for people from Germany. By the same token, a "German-speaking" facility would hardly be feasible in Thailand due to the lack of German-speaking personnel.

Conclusion

Our results show that both facilities legitimise themselves particularly by emphasising the special care they offer and its quality. In the process, both of them reveal Germany and the discourses circulating in Germany to be the resonance space for the evaluation of care arrangements. They position themselves as qualitatively superior in relation to current residential old age care realities in Germany, while at the same time countering possible fears of potential difficulties linked to moving care abroad. Our study of the facilities in Poland particularly, the majority of which stresses their lower prices and position themselves as "low cost facilities for people from Germany," shows that they barely manage to attract an appreciable number of people from Germany, if any at all (Großmann & Schweppe

2018). Low costs alone do not pave the way into the facilities abroad. As Großmann and Schweppe state (2018: 17):

By offering lower costs they do address a severe problem of old age care facilities in Germany but (...) they do not take up or refute the arguments that reject the use of a care facility abroad due to linguistic or cultural differences, fears of alienation or which associate poor quality with care abroad. Compared to the argumentation of the facility projecting itself by 'Just like in Germany, only better', these facilities rather position themselves as 'low cost facilities for people from Germany'.

Suchman (1995) argues that to positively answer the question 'is it the right thing to do', which he considers as an important element to accord legitimacy "reflects a positive normative evaluation of the organisation and its activities" and depends on "whether the activity effectively promotes societal welfare, as defined by the audience's socially construed value system" (579). The relatively high take-up of the facility presented here by people from Germany, with the relatives often taking an important part in the decision-making process, points to the significance people attach to quality old age care and to knowing that their family members with long-term care needs will be well looked after.

From this perspective, our results also show that care abroad is not - as sometimes propagated in the media - about "deporting" and "dumping" older people with care needs, but it is more about concern and the search for better care options.

Our results show some similarities with studies examining the placement agencies for migrant care workers for private households and their establishment old age care market. A decisive element in their case, too, is the construction of a care option as being qualitatively superior compared to the other alternatives available in Germany. These agencies position themselves as actors making "their commercial offer of care (...) explicitly as a more social and human alternative to the taylorized health care provided by the public sector" (Schwiter et al. 2014: 213; translation by the authors; also Krawietz 2014). Seen in this light, the establishment of new actors in the old age care market is a lucrative business, which is grounded in the concerns about, and the search for, more humanly and dignified old care options as a consequence of the public care system's shortcomings in Germany. Our research shows, however, that

some facilities hold up to their promises better than others. In fact, due to the diversity of old age facilities in Thailand as well as in Poland, it is difficult to draw simple conclusions. Careful case-by-case analysis is required to scrutinise whether and how these facilities offer old age care options that go beyond the current shortcomings of old age care in Germany (Horn et al. 2016).

Corresponding author

Cornelia Schweppe, Institute of Education, Johannes Gutenberg University, Georg-Forster-Gebäude, Jakob Welder Weg 12, DE-55099 Mainz, Germany. Email: schweppe@uni-mainz.de

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Mark Schweda, Larissa Pfaller, Kai Brauer,
Frank Adloff and Silke Schicktanz (eds.)
(2017). *Planning Later Life. Bioethics and
Public Health in Ageing Societies*. Abingdon/
New York: Taylor & Francis [Routledge
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*REVIEWED by MALTE VÖLK**

The conceptual linchpin of this volume, as it is laid out in the introduction and in the editor's further contributions, is the juxtaposition of contemporary Ageing Studies and a perspective on human life that sees as given a somehow predetermined life course. The book's title, *Planning Later Life*, is to be understood in such a context, embedded in the broader question: How do different cultural fields – medicine being one of the most important ones – define what is appropriate for the aged? Ethical and philosophical considerations as well as case studies from different parts of the world try to determine what influence these cultural images have on the individual and societal planning of later life. In order to implement its complex and ambitious combination of individual and societal aspects of ageing societies, the book brings together contributions from distinguished scholars,

*Malte Völk, Department of Social Anthropology and Cultural Studies, University of Zurich, Zurich, Switzerland

often building on the results of many years of research – conducted in different fields of science and humanities, allowing for the combination of philosophical, bio-ethical, anthropological and sociological viewpoints and providing fruitful insights into a central issue of human development in the light of growing life expectancies.

The book consists of three parts. The first part with contributions from Mark Schweda, Thomas Rentsch, François Höpflinger and Paul Higgs/Chris Gillear looks at “Conceptions of ageing and old age” in a rather broad scope. With a main emphasis on philosophical and sociological perspectives, the changes in those conceptions are identified and reflected, especially in terms of notions of a naturally determined life course that not only create images of age-appropriate behaviour but can lead to grave consequences in the area of public health. The second part, entitled “Perspectives and problems of old age in the context of medicine and healthcare,” combines contributions from Andreas Kruse, Perla Werner/Silke Schicktanz, Hsiu-I Yang, Søren Holm and Nancy S. Jecker. Here, a variety of specific issues are discussed, ranging from old age in modern society over ethical questions alongside the occurrence of dementia and end-of-life decisions to bio-technological life extensions. The last part of the book, with contributions from Kai Brauer, Ralf J. Jox, S. Jay Olshansky, Larissa Pfaller/Frank Adloff, Silke Schicktanz, Ruud ter Meulen and Stephen Katz/Peter J. Whitehouse, focuses on the current modes of strategies of planning later life, analysing the efforts of countering its individual and societal contingency.

What these three parts have in common is a critical view on normative and still widespread conceptions that tend to repress and devalue old age. One reaction towards these could be to change the perspective and focus on the question what societies can learn from the phenomenon of ageing. The answer, according to Rentsch, is that the fact and meaning of ageing let society gain valuable reflections on modesty. The answer is even outperformed by Katz/Whitehouse: “Globally, rather than being a mega-problem, ageing [...] can be inverted to become a mega-solution because the transfer of human repositories of experience, stories and wisdom is one way to deepen resistance to social instability” (Katz/Whitehouse 2017: 250).

However, the idea of turning the tables should not be confused with another normative conception that would aim at “replacing one biased

stereotype of old age with another, thus merely reversing the value system that informs ethical discourse" (Schweda 2017: 26). Rejecting one-dimensional ethical viewpoints, Schweda demonstrates how different sets of meaning and value are attributed to different stages of life through internalised stereotypes. Such implicit pictures of a natural life course can become dangerously explicit when medical treatment is needed: studies show that the age of individuals does in fact influence decisions in a way that indicates costly treatments seem to be seen as less worthwhile when older people would benefit from them.

In a similar vein, Andreas Kruse in his definition of seven factors that should constitute an "age-friendly culture" demands as a central point: "Decisive for healthcare provision is the diagnosis alone, made by an expert, not the age of the individual concerned" (Kruse 2017: 87). This manifesto for duly balanced intergenerational relationships, that also includes aspects like workplace environments and societal communication, is derived from an analysis of the general nature of old age today that is shaped by the observation of two human strains of ageing: While the perils of the physical process of ageing need not be denied, they are getting too much attention and divert the view on "the potential wealth that can unfold in the ageing process" (Kruse 2017: 75) in terms of mental experience. But this is not to be understood as a sharp distinction between a positive (active, participative) "third age" and a "fourth age," which might not be worth living anymore. Conceptions like these are contested by many of the contributions gathered here, and Kruse also argues that even in situations of extreme vulnerability like severe dementia, there can still be individual emotional experience and meaningful interactions, as evidenced by empirical research. Thus, the quality of life cannot be measured in universal scales. The same problem seems to apply for scales and measurements of decision-making competence in the process of cognitive deterioration: an area, where still "not enough attention is being paid to ethical issues" (Werner/Schicktanz 2017: 97), as Perla Werner and Silke Schicktanz point out.

Hsiu-I Yang raises a topic that extends ethical questions like these towards life-sustaining medical technology. Her thoughts are restricted to cases without chances of healing or even the regaining of consciousness – but still, as she proposes to grant individuals above the age of 80 years a "peaceful death" (Yang 2017: 110) and wishes to establish "a

mature culture of death, in which old people can live longer and healthier and die quicker and fitter" (Yang 2017: 113), her line of argumentation is not free from the notion of a natural life course with fixed stages: how else could having lived a "full life" be understood as having turned 80, as she defines it?

The contributions presented in this book display the current state of discussions in Ageing Studies, and with their specific focus on the expected future scenarios and planning processes, they bring out the dynamics of ageing societies in an impressive way. It has to be mentioned, though, that the strength of the volume does not lie in the interaction of the articles. Their heterogeneity can be obtrusive at times. Still, the benefits of the diverse range of topics and disciplines outweigh this point, which is also a marker for the necessity of ongoing discussions in the dynamic field of Ageing Studies. For this, *Planning Later Life* provides some excellent foundations that can prove to be important for scholars from various disciplines.

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Paul Higgs and Chris Gilleard (2016).
*Personhood, Identity and Care in
Advanced Old Age*. Bristol: Policy Press.
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REVIEWED by MICHAEL FINE*

Paul Higgs and Chris Gilleard, two British cultural sociologists familiar to the readers of this journal, have a prolific publishing record. They are perhaps best known for a series of books and articles on the topic of “cultures of ageing,” a phrase they used as the title of what is surely one of the most important and influential books published in the field of cultural gerontology (Gilleard & Higgs 2000).

This book, *Personhood, Identity and Care in Advanced Old Age*, builds on and consolidates a number of central concerns in their most recent writings on what they refer to as “the fourth age” (Gilleard & Higgs 2010; Higgs & Gilleard 2014, 2015) which follows and contrasts with the “active ageing” of the third age. The book addresses the fourth age as a life stage involving “ageing without agency,” a final and abject period of life that both reflects and underlies the experience of frailty and dependency in the final advanced years of a long life. They frame this final stage of life as a “social imaginary,” a culturally shared understanding of the humiliation, dependency, impotence, infirmity and abjection that they argue “seems to surround the social position of those at the extremes

*Michael Fine, Department of Sociology, Macquarie University, Sydney, Australia

of later life." They then draw on this analysis to examine the limits to care; the possibilities that circumscribe both informal and formal care relationships; and the links between ageing, modernity and identity. The result is a theoretically rich, exciting, controversial, important, if at times ponderous, and densely written treatise on the possibilities of care in advanced old age.

Higgs and Gilleard thus narrow their focus in this book from the general topic of the social and cultural construction of ageing to a theoretical argument about care at the end of life. They are not the first to identify the limitations and problems of care in these circumstances but stand out in taking a stance that exposes and challenges many of the commonly accepted platitudes that seek to cover up the dilemmas faced in the provision of such ongoing assistance.

Responding to the writings of Kitwood and Bredin (1992), they take particular aim at the concept of "personhood." Recognising the enduring personhood of people with advanced dementia is widely invoked as a sort of incantation for staff assigned to provide care to those with advanced dementia, it is not a satisfactory practical solution. Higgs and Gilleard argue that although the personhood approach calls on care staff to morally recognise the enduring personhood of such chronic care recipients, the recipients are no longer able to respond as full persons, because fourth age are recipients, by definition, lack the capacity to exercise agency or express full personhood. In such circumstances, the recipients are inherently vulnerable and dependent and providing care becomes increasingly one-sided.

Addressing the already considerable literature on both care and old age, Higgs and Gilleard present a quite in-depth review of much of the existing theory and some empirical research on each of the key terms in their theory. This approach provides the book's structure. Following an introductory chapter that provides an overview of the main argument, two chapters chart and review the literature regarding the meaning of the terms "personhood", "agency" and "identity", finding a significant difference in emphasis and meaning in the terms as used by philosophers, sociologists, other social scientists and popular culture. Using a similar theoretical and critical approach to the literature, the next two chapters analyse the concepts of frailty and abjection in some detail.

A further two chapters then examine the theory and research on care – contrasting care based on informal caregiving for and between intimate family members with formal care, based on paid work, where the caring is concerned with the support of strangers. The result is a bleak portrayal of support in the final years that valorises informal care provided in families but points to its limits and the impact on family carers. It provides an even less optimistic analysis of the options for formal care. In the penultimate chapter, that seems to have been written with a view to providing some sense of hope, the authors write of “care without limits.” It focuses on the support of those with advanced dementia as a proxy for those advanced age, identifying a stage in which people need care but are unable to actively exercise their rights and instead must depend on those responsible for their care.

Although some research results are reported from the literature, the book is most definitely not an empirical research study with a Cochrane-like statement of established evidence. Rather, its intent and value is as theory, the conclusions providing a rich set of well-founded propositions, interpretations and argument with which to both guide further research on the one hand and stimulate reflection and invite further conceptual analysis on the other hand. The cultural analysis approach, which remains central to the theory construction, draws together key concepts such as “abjection” and “personhood” that are essentially symbolic and interpretative concepts with elements such as the experience of receiving care that may draw on observational as well as other qualitative, possibly subjective forms of data collection.

While some level of dispute is likely to arise over the practical questions of implementation and care practices – the impact of particular care settings, the approach of different teams and the practice of care under a range of different national or policy circumstances – others remain conceptual. I found myself constantly questioning the framing of the issue around the relevance of concepts such as the fourth age and abjection. Don't the arguments advanced about advanced age apply equally to the experience of conditions of severe and profound disability? If so, is this meditation on care really about the fourth age or about care where high levels of dependency are evident? Palliative care for dementia is touched upon briefly, but the broader topic of euthanasia or palliative care at the

end of life is not explored in any depth. Yet, these topics seem to fit the model centrally in terms of life stage and descriptions of dependency advanced by Higgs and Gilleard. The concept of abjection is also difficult as it seems to be used tautologically, as both the cause and the outcome of the very problems, such as sequestration and dependency, it seeks to explain. Is abjection essentially a term of description, or is it a cause or explanation? Indeed, might the entire argument be used simply as a sort of sophisticated justification for abandoning hope?

Perhaps the message emerging from the shadows of the book's analysis might be a need to confront the final stage of life by taking control at an early point, perhaps through euthanasia or technology. If the fourth age is best understood as a social imaginary rather than as a fact of life, might it be possible to replace the popular belief in decline and the need for care in the final years of life with a more realistic appraisal? If so, under what conditions?

The argument advanced in this book raises questions and doubts for other readers as it did for me; it will have more than served a valuable service. While it is unsettling, raising questions rather than providing answers, this is clearly the most stimulating theoretical account of the possibilities and limits of care in advanced old age that I have read. I strongly recommend it and hope that other researchers and practitioners will read this book and join the debate.

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Stephen Katz (ed.) (2018). *Ageing in Everyday Life. Materialities and Embodiments*. Bristol: Policy Press, 208 pp. ISBN 978-1447335917 (hardback)

REVIEWED by JOYCE WEIL*

Drawing from multiple bodies of theory and methodological approaches, Katz's edited volume achieves its mission: reminding us that ageing and older adults are often missing from both sociological discourses and discussions of intersectionality – that is, marginalisation rather than inclusion. This book shows the “materialities” and “embodiment” of ageing focusing on the complexity and influence of the material world upon constructed reality and lived experience of ageing and later life. Katz's selected authors put in context the work of Simmel, who writes that “the essence of aesthetic observation and interpretation comes from finding the typical in the unique” and that the beauty and “total meaning of the world as a whole radiates from every single point” (p. 7).

Structurally, *Ageing in Everyday Life* is part of the Ageing in a Global Context series. After Katz's (2018) introduction, the book has two sections, Materialities and Embodiments, each briefly introduced by Katz. The sections contain five chapters; an afterword ends the book. In Katz's text, *Materialities* refer to the “various places, technology, things, rhythms,

*Joyce Weil, Gerontology Program, College of Natural and Health Sciences, University of Northern Colorado, Greeley, CO, USA

designs, mobilities, and environments in which our experience of ageing is grounded and observable" (p. 1). *Embodiments* refer to "the orientation to bodily life as a site where dominant cultural narratives and forms of expertise about ageing gather" (p. 126).

In Part 1, "Materialities," Katz's introduction raises the issue of transience and mobility with material possessions as a constant amongst places. Items taken along are mutable ways to track identity. Ekerdt's chapter, "Things and possessions," uses United States Health and Retirement Survey (HRS) data to illustrate the material convoy, items accumulated throughout the lifecourse. Collecting things helps form identity, but items can be a weight and need to be managed. Ekerdt uses HRS data to show that divestment of things is not typical with age. Next steps for research could show how meaning/attachments to things may change at different points in one's lifecourse (i.e. something once valued highly may be discarded at another age).

Braedley's "Reinventing the nursing home" uses photovoice and ethnography to explain how ruling metaphors apply the design of other places, such as a hospital, hotel or home, to nursing-home design. The hospital metaphor portrays skilled care as sterile and with a medical lens. The home metaphor is domestic but sanitised, and the hotel metaphor uses tropes such as chandeliers, flowers and chef-based buffet. Ruling metaphors are problematic because they proscribe the material conditions, organisation infrastructure and relationships for nursing-home residents – controlling residents' lives and limiting innovation in nursing-home concept development. Ruling metaphors are like shadow institutions that never reach the fantasy they seek.

Gavin and Grenier's "The every-breaking wave of everyday life" applies nonrepresentational theory (NRT) to older peoples' movement in everyday life. They challenge long-held views of movement as biomechanics akin to active ageing. They replace it with concepts based upon the rhythm of everyday life. For example, momentum looks at how past behaviours positively (being swept up) or negatively (being lost) persist. Infectiousness is not contagion, but feelings passed between people that can change peoples' lives. Encountering is a favourable interruption each day to create one's world. This NRT approach suggests we must develop new methodologies and lenses to see the world of movement for older adults.

Chivers' "What's exotic about The Best Exotic Marigold Hotel?" looks at the silver screen as a vehicle for perpetuating ageism. She shows how a hotel in India for retired English people serves as a colonial outpost substitute. The English older adults are depicted as having know-how, while the South-Asian older adults are portrayed as child-like. Chivers describes how the film portrays ageism hidden behind an exotic setting with complicated images of India as the mystical east, exotic and commonplace at the same time.

Rozanova, Wada and Hurd Clarke's "Between ageing and ageism" uses Goffman's spoiled identities to evaluate older adults' online dating presence. They found that these dating sites are youth-centric and seen as so novel that they were covered in news media. Through ethnographic analysis, the authors found that such sites define the "good" ageing body and normalise sex and dating in later life but also pose risks of too quickly forming emotional intimacy. The authors question whether online dating and romance are the electronic version of successful ageing.

In Part II, Embodiments, Katz's introduction raises the crucial point: even in embodiment work, older adults' bodies are often absent. Sandberg's "Closer to touch" examines older men's sexuality through their own diary entries, moving the discussion of sexuality beyond solely potency. This true embodied approach produces views often unexplored – older men missing intimacy, differences between physical and emotional intimacy becoming clearer, an increased need for skin-skin contact, and the impact of loss and illness on intimacy. All themes pointed out the real humanity of touch.

Gish, Grenier and Vrkljan's "Ageing bodies, driving and change" reframes how we look at fit between new Advanced Vehicle Technologies (AVT; e.g. dashboard GPS, backup sensors) and older bodies. Their interviews with older drivers explore the human-machine interface. Some older adults described AVT making them feel disconnected from the driving experience with former driving habits (looking over one's shoulder) not needed anymore. Others described benefits of AVT. The researchers called for car manufacturers to consider real human factors in ageing when making changes.

Kontos and Grigorovich's "Dancing with dementia" finds dance helps assert personhood. Through their observational work in a skilled-care

facility, the authors found dance rituals maintained identity of Hassidic residents. Dance expressed passion during prayer in religious services. Dance happened as unstructured, serendipitous movement in hallways (e.g. a woman in a wheelchair freely moving her arms and dancing for joy). Dance is an embodied selfhood raising body consciousness and revealing cultural embodiments – especially for those with dementia. The researchers call for dance programmes to utilise dance’s therapeutic effects and build upon human capacity, not loss.

Twigg’s “Why clothes matter” explores how clothes are both an intimate experience and a public expression. Clothes reflect how society constructs and assesses successful ageing by dress. Twigg studied older women in the UK and found ideas of lost style and lost pleasure in dress, but older women also felt they shed the “pinney” of their grandmothers and dressed much better at the same age. Women did not want to dress “old” but noted added surveillance of dressing for older women (e.g. Is the outfit the new style? Hides the ageing body?). Clothes, being the environment closest in, act as a vehicle of remembrance, with the clothed body becoming a site for the politics of ageing to play out.

“Our Fitbits, our (ageing) selves,” by Marshall, reviews how devices regulate everyday life of older adults via the quantification of movement. While marketed as ways to keep older adults young and independent, these devices confirm more than steps. They influence identity and “successful” ageing regulation, making older adults “live by the numbers” (p. 197). Marshall deftly uses narrative, such as the woman who compares her reaction to her device’s vibrations to a “pigeon getting its pellet” (p. 203). Marshall calls adults to challenge the dictation of exercise as the only definition of health and resist using movement to colonise the ageing body.

Sawchuk’s “Afterword” sums up themes with Butler’s apt quote: “We cannot talk about a body without knowing what supports the body and what its relation to that support – or lack of support – might be” (p. 223).

The flow and placement of chapters ground ethereal materialities and embodiment in the words of older adults. The overall text shifts the older body as object of biomedical and other surveillance and regulation to a site (and struggle) for identity expression. While Katz chooses chapters

addressing materialities and embodiment concepts, the materialities–embodiment pair of terms is historically intertwined with complex and interrelated relationships, understandings and meanings. The chapters clearly show the intersection of the materialisms–embodiment concepts and, therefore, could be placed in either section due to the fluid relationship of the materialisms–embodiment pair. *Ageing in Everyday Life's* strength is exploring the closely linked relationship between the concepts of materialities and embodiments. Is then dividing the readings into two separate parts (Part I: Materialities and Part II: Embodiments) at all necessary? Do these two parts impose divisions in the suggested fluidity of the materialities–embodiments continuum? Building upon the cover photo of a personified weathered boat, more visual representation – such as photo elicitation – could deepen the look at older adults seen in the work. Additionally, it would be helpful to see how the materialities concept works in non-western settings. And, could same relationships of older persons and things occur in a less materialistic culture where things may hold less attachment?

In conclusion, this edited volume is a vital contribution to the fields of gerontology and sociology, amongst others, as it reframes how we look at the everyday experience of ageing without reductionistic labels and lenses of health or activity. The chapters move beyond ageing materialities and embodiments, past surveillance and external markers of good embodiment – such as healthy or successful ageing. Including significant first-hand narratives keeps the older body heard and seen in the work.

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I J A L

International Journal of Ageing and Later Life

The International Journal of Ageing and Later Life (IJAL) serves an audience interested in social and cultural aspects of ageing and later life development. As such, the Journal welcomes contributions that aim at advancing the conceptual and theoretical debates of relevance on ageing and later life research. Contributions based on empirical work as well as methodologically interested discussions are also welcome, as long as they contribute to the above-mentioned discussions.

Being an international journal, IJAL acknowledges the need to understand the cultural diversity and context dependency of ageing and later life. The journal accepts country- or cultural-specific studies that do not necessarily include international comparisons as long as such contributions are interesting and understandable for an international audience.

IJAL publishes articles based on original research and includes a book review section, which ensures that readers are kept in touch with new work and current debate. To assure high scholarly standard IJAL uses a double-blind review process. In order to stimulate exchange of ideas on ageing across many parts of the world, IJAL does not charge authors for their submissions and has been available free of charge to anyone with Internet access (<https://journal.ep.liu.se/index.php/IJAL/>).