Social Politics 2020 Volume 0 Number 0

Comparing Care Regimes: Worker Characteristics and Wage Penalties in the Global Care Chain

Naomi Lightman *

This study uses 2010–2014 Luxembourg Income Study data to measure care work quantitatively within and across four care regimes, with a particular focus on the reliance on migrant women for low-wage, low-status work in health, education, social work, and domestic services. Care regimes are examined in order to highlight similarities and differences in twelve care economies: while liberal and corporatist care regimes are found to display a "migrant in the market" model of employment, familialistic and social democratic regimes exhibit somewhat different employment trends yet continue to financially undervalue highly feminized work in care.

Introduction

There is growing consensus that welfare regimes, in themselves, are an incomplete classificatory mechanism to comparatively analyze low-status work in health, education, social work, and domestic services ("care work") and do not allow scholars to adequately trace the flow of female migrant workers moving from poorer to richer countries to provide caring services (Da Roit and Weicht 2013; Kilkey, Lutz, and Palenga-Möllenbeck 2010). Partially as a consequence, the suggestion is made that welfare regime classifications are male-centric and outdated in this context, and/or that differences within categories are more important than differences among them (e.g., Blofield and Franzoni 2014; Brennan et al. 2012; Jensen and Lolle 2013). Williams (2012), for example, identifies considerable convergence in the provisioning of health and domestic services across wealthy European nations, both in the commodification of care services and in the employment of migrant women.

In place of traditional welfare regime studies, analyses of care "regimes" have emerged (see, e.g., Albertini 2014; Van Hooren 2012). Care regimes allow

University of Calgary
*naomi.lightman@ucalgary.ca

socpol: Social Politics, Summer 2020 pp. 1–28
doi:10.1093/sp/jxaa008

for greater focus on the particularities of national care economies and shed light on the "invisible [migrant] workers" (Ranci et al. 2019, 19) providing care, often without the social, civil, or economic rights provided to non-immigrant workers. Thus, while the majority of care work studies continue to be qualitative or to focus on a single country of analysis, growing understanding of the "globalization of care" (Hochschild 2000; Misra, Woodring, and Merz 2006) has facilitated cross-national analyses of care regimes. Such studies examine the consequences of disparate regulatory and/or migration regimes structuring care work (Lutz 2017; Van Hooren 2014), care workers' variable integration and/or job satisfaction in different national settings (Lightman and Kevins 2019; Ranci et al. 2019), or assess the growing precarity within the care workforce (Jokela 2019). However, to date, there has been no large-scale quantitative analysis of differences and similarities in worker characteristics and wage penalties for migrant workers across multiple care regimes.

The current study is an effort to address this shortcoming. I quantitatively measure care work within and across four care regimes—liberal, familialistic, corporatist, and social democratic—with a particular focus on the reliance on migrant women for low-wage, low-status work in care. In addition, I seek to quantify any "care wage penalty" associated with low-status care work for female migrants across regime type. Using the microdata files of the 2010–2014 Luxembourg Income Study (LIS), I examine who is employed in care work across twelve countries and measure the earnings penalty faced by low-status female immigrant care workers, in order to address the following key questions:

(1) Do care regimes display similar (or different) trends in terms of the characteristics of workers in their national care economies?
(2) Are (female) immigrant workers more (or less) likely to work in low-status care work than equivalent non-immigrant workers regardless of care regime?
(3) Does care work continue to impose a wage penalty, even when controlling for gender, immigrant status, country-level variation, and care regime type?

Ultimately, I find that in the majority of case study countries, women and immigrants are more likely to work in low-status care than men and non-immigrants with equivalent human capital. Pooled country models also demonstrate that a care wage penalty persists even when controlling for country-level variation and care regime type, with cumulative penalties experienced by women and immigrants. Thus, altogether, this paper contributes to the existing care work literatures by adding a large-scale cross-national care regime comparison and providing nuance to prior suggestions of a care economy convergence: while similarities in the worker characteristics and working conditions of care workers emerge across liberal and corporatist care regimes

(which display a "migrant in the market" model of employment), southern European care economies appear to be more reliant on familialistic and informal care, and social democratic care regimes to have overall less of a reliance on migrant workers.

Migrant Women and the Devaluation of Low-Status Paid Care

Care work, often associated with "women's work", is typically defined as employment that involves face-to-face interactions with children, the elderly, or people with complex healthcare needs (England, Budig, and Folbre 2002; Folbre 2012). It is frequently found to be undervalued and underpaid. Scholars seeking to unpack this devaluation typically provide three main explanations. First, the characteristics of care workers themselves (as a disproportionately female, racialized, and immigrant workforce) often lead to labor market disadvantages (Duffy, Albelda, and Hammonds 2013; Folbre 2012). Second, in the case of low-status care work, individuals are often negatively selected into these occupations based on low levels of education and other human capital, resulting in lower wages (England, Budig, and Folbre 2002; Lightman 2019). Finally, the nature of care work itself devalues earnings, as such work is often precarious and part time, and/or located in the unregulated private sector, where both care outcomes and working conditions for care workers are found to be poor, irrespective of the income level of the country (Addati et al. 2018; Jokela 2019; Van Hooren 2012).

Prior research has established a need to specify definitions of paid care: this is due to substantial wage variation within the caring industries of health, education, and social work, and the tendency within care work literatures to focus on low-status, nonprofessional caring jobs (Van Hooren 2014; Weedon 2002). Barron and West (2013), for example, demonstrate a statistically significant wage penalty associated with working in caring occupations requiring lower levels of educational qualifications, such as nursing assistants and auxiliaries, in the UK. Yet, they find that in other caring occupations, such as medicine and teaching, wages are higher than in comparable non-caring jobs. Thus, the authors conclude that "although previous research in this area has suggested that the majority of the caring occupations face a wage penalty, the results reported here show that a more nuanced understanding of the status of care work is needed" (Barron and West 2013, 118).

Increasingly, however, both high- and low-status care employment is conceptualized within a transnational labor market (or "global care chain") (Hochschild 2000) where disadvantaged or poor immigrant women provide care for pay in wealthier countries, typically in lower-paying service jobs (Lutz 2017; Van Hooren 2014). In this context, migrant workers provide a market-based solution to national labor market shortages, often arriving with

temporary work permits designed to discourage their broader integration or settlement (Anderson and Shutes 2014; Parreñas 2013). In the case of higher-status care workers, research finds that migrant workers often have difficulty transferring their credentials or lack local work experience, leading to difficulties in finding professional care employment commensurate with their qualifications (Lightman 2019; Williams 2012).

Intersectional care work scholarship highlights how gendering, racializing, and deskilling are associated with paid caring jobs and tied to broader understandings about the undesirability of non-white individuals as (future) permanent members of society (Sharma 2006); gendered understandings of care work as essentially a feminine undertaking (Folbre 2012); and political decisions not to recognize "caring skills" (even when backed with tertiary education credentials in subjects such as nursing) as ones that qualify a person as highly skilled (Boucher 2019; Elrick and Lightman 2016). Negative social and economic outcomes are also well documented within care work and are attributed to further intersectional dynamics associated with vulnerable employment conditions which may lead to workplace exploitation and abuse; truncated social networks outside the care work sector; and poor pay leading to an inability to finance expensive requalification programs upon migrating in order to achieve social mobility (Banerjee et al. 2018; Tungohan 2018).

According to recent data from the International Labor Organization, women comprise 73.4 percent of all migrant domestic workers worldwide. Among female migrant workers, 13 percent are domestic workers, while only 4 percent of male migrant workers are engaged in paid domestic work (King-Dejardin 2019). Thus, across numerous care regimes, low-status female migrant labor has become a defining feature of the care economy (Folbre 2012; Williams and Gavanas 2008). Van Hooren (2012), for example, finds that (female) migrant employees work longer hours and do more night shifts than their native-born peers in elder care within liberal care regimes. In corporatist care regimes, Shire (2015) finds that new policies in support of families have led to a growing reliance on migrant women in the realm of private domestic household work. As a third example, in a comparison of Spain and Sweden, Hellgren (2015) notes that despite the different characteristics of their welfare regimes and labor markets, there are nonetheless similar results for migrant care workers, who she argues have become an important and growing component of a "migrant precariat".

Building on this existing scholarship, the current study provides a cross-national quantitative comparison of the care economy in twelve countries, with a particular focus on female migrant care workers. I examine both the characteristics of workers in the care economy across and within four care regimes using nation-level data, as well as using pooled country models to assess any wage penalty for care work, controlling for country-level variation and care regime type. By providing a larger-scale analysis of worker

characteristics and wage penalties in care, a more nuanced analysis of similarities and differences across and within care regimes emerges.

Care Regimes and a Globalized Care Market

The application of care regimes as a heuristic device to conceptualize and measure similarities and differences in social care provisioning at the cross-national level builds on feminist critiques of Esping-Andersen's (1990) formative typology of welfare regimes in *The Three Worlds of Welfare Capitalism*. Scholars advancing the use of care regimes posit that it attracts scholars' attention to "the nexus between the family and the state" (Albertini 2014, 135) and is useful both to analyze specificities of national care economies and to "bundle" countries together which display similar characteristics, in terms of the degree of decommodification and stratification within the care economy and the reliance on female migrant workers (León 2016; Williams 2012).

Van Hooren (2012), in particular, lays out three ideal-typical care regimes, which she states "follow" Esping-Andersen's typology, but allow for better understanding of the working conditions within the social care sector, specifically for women and immigrant workers (135). The first are *liberal* care regimes. Here, Van Hooren (2012) suggests that care services are primarily purchased on the market by individuals and the state does not guarantee universal access. This leads to the outsourcing of large components of the care economy to private agencies (Folbre 2012). Indeed, prior comparative care research has found that within liberal care economies migrant workers are employed disproportionately in low-status, low-wage types of care and incur additional wage penalties compared to non-immigrant care workers. This phenomenon has been termed a "migrant in the market" model of employment (Lightman 2019; Van Hooren 2012).

Van Hooren's second ideal-typical care regime is termed *social-democratic*. In contrast to liberal care regimes, here universal access to care services is provided for everyone in need, independent of income or family circumstances. Also inherent in this care regime is an assumption of gender equality and the facilitation of a dual-earner career model. Thus, care work is defamilialized, while also providing well-paid employment opportunities for women within the public sector (Eydal and Rostgaard 2016; Rostgaard 2014). According to Van Hooren (2012), the availability of publicly financed care services within social democratic care regimes often "crowds out" demand for private care, as large public investments in public services make the care sector attractive for native-born employees. This decreases dependence on foreign labor, creating "no particular demand" (144) for migrant care workers.

The third ideal-typical care regime detailed by Van Hooren (2012) is labeled *familialistic*. Here, family members have a (legal) obligation to care for dependent family members and public care provisioning is provided only

when the family is unable to provide care: consequently, this approach is strongly means- and needs-tested. Using Spain and Italy as examples, Van Hooren (2012) notes that where there is demand for paid care services in familialistic regimes, migrants are often employed directly by the family or within the gray or informal market, leading to a "migrant in the family" model of employment. Thus, this care classification aligns most closely with characteristics of the southern European countries analyzed in this study, due to their limited levels of social security and strong family-orientation. It is suggested that the high reliance on the informal and voluntary sector for care work in familialistic care regimes may lead to lower overall levels of paid work in care, as well as, potentially, to challenges in measuring the presence of migrant care workers, as many function outside the formal labor market (Isakjee 2017; Ranci et al. 2019).

Finally, while Van Hooren (2012) does not reference or classify *corporatist* care regimes in particular, within care scholarship continental European countries (e.g., France, Germany, Belgium, and Austria) are often found to demonstrate distinct trends in care provisioning (Misra and Moller 2005). Corporatist care regimes are thought to provide a "mixed" model, relying more on family and labor market policies that promote a traditional or modified male breadwinner model than liberal or social democratic regimes (Lutz 2017; Schober 2014; Shire 2015), but having supportive parental leave policies, paid sick child benefits, and childcare services that are substantially more developed than within familialistic care regimes (Isakjee 2017; King-Dejardin 2019). As such, corporatist care regimes may lead to a "migrant in the middle" model of employment, whereby migrants work in low-wage and private-sector care jobs, similar to in liberal care regimes, but enjoy greater worker protections due to a stronger role for unions and European conventions. Table 1 provides a summary of this care regime typology.

Internationally, scholars have noted that shifts toward (greater) austerity and retrenchment in welfare state provisioning across the Global North have led to a blurring of care regime differences, along with a growing reliance on low-wage female migrant labor in the private sector that is emblematic of the "migrant in the market" model (Cortez 2008; Lombardo 2017). Fagertun (2017), for example, notes that neoliberal trends in care provisioning have led to a "re-familialization and re-informalization" of care work, pushing it to private and informal markets where the burden is born disproportionately by disadvantaged (immigrant) women. Thus, to assess the current validity of a care regime typology, and to measure empirically the similarities and differences within and across four care regimes, the following section outlines the research design developed and applied. The goal is to examine whether the paid workforce in each care regime is distinctive, in terms of its worker characteristics and wage penalties, or whether trends toward a "care convergence" under conditions of neoliberal globalization have diminished cross-national differences within the paid care market.

Table 1. Care regime typology

Care regime	Liberal	Corporatist	Familialistic	Social Democratic
Care policy structure	*The market/private provision* of care is purchased by most individuals. Care is not publicly guaranteed to all	*Mixed* systems of social welfare provision. Typically, there is statutory social insurance and stronger state coordination than in familialistic regimes, but more reliance on a male-breadwinner model than in liberal or social democratic regimes	*The family* is the main legal actor responsible for care	*The state* provides universal access to care
Impact on migrant workers	"Migrant in the market" (migrants work in low-wage jobs, typically in the private sector, providing care)	"Migrant in the middle" (migrants are typically located in low-wage and private-sector care jobs, similar to liberal regimes, but may enjoy greater worker protections due to a stronger role for unions and European conventions)	"Migrant in the family" (migrants are hired, often informally, by families to provide care at home)	No particular demand for migrant workers

Source: Adapted from Van Hooren (2012).

Research Design

To examine care work in as much detail as possible within four care regimes—liberal, corporatist, familialistic, and social democratic—this study uses the microdata files available from the LIS. The LIS gathers cross-sectional data from household-based national surveys and harmonizes the data to ensure comparability, providing among the best cross-national data available for comparing incomes. Countries are selected into a given care regime based on the policy structure of their existing care economy at the time of data collection. All countries that fit within one of the four care regimes are included where information is provided on immigrant status, occupation, and industry of respondent. In practice, this entails relying on 2010–2014 data (Waves VIII and IX of the LIS), as the most recent datafile in certain countries (e.g., Canada) lacks required information on industry or occupation of respondents.

The sample is limited to employed individuals aged 18–70 years, with a focus on people working in lower-status caring occupations, for example, personal care workers, healthcare assistants, domestic housekeepers, babysitters, and teachers' aides. As a consequence, managers, professionals, skilled agricultural, forestry and fishery workers, trades persons, machine operators, and individuals working in the armed forces are excluded. This results in a final pooled sample size of 105,495 respondents, with per-country samples ranging from 2,430 in Greece to 35,268 in Denmark.

Australia (2014), Canada (2010), Switzerland (2013), and the United States (2013) are classified as "liberal" care regimes; Austria (2013), France (2010), and Germany (2013) are identified as "corporatist"; Spain (2013), Italy (2010), and Greece (2013) represent the "familialistic" care regimes; and Denmark (2010) and the Netherlands (2013) represent "social democratic" care regimes. Certain countries, such as Ireland, are excluded from the analysis because there are too few immigrants in the sample for reliable estimates, while others (e.g., Sweden, the UK) are excluded because they do not provide requisite data on immigrant status.

Classifying Work in Care

As noted in the literature review above, the concept of "care work" is operationalized in highly disparate ways within existing cross-national comparisons of paid care (e.g., Duffy and Armenia 2019; Duffy, Albelda, and Hammonds 2013; Lightman 2019). For this analysis, I follow recent work by Duffy and Armenia (2019), who take an "industry approach to care" (6) and focus on both direct (face to face) and indirect (supporting) care sectors, identifying individuals working for pay in *education, health, residential care, social work*, and *domestic activities in private households*. For this, I rely on the LIS standardized industry variable. Previous research has found a "care [wage] bonus" for professional (or higher-status) jobs in health and education

(Lightman 2017). Given that a goal of this analysis is to focus specifically on lower-status caring jobs where women and immigrants are often overrepresented—the focus here is *not* on managers and professionals in health and education, such as hospital executives, doctors, or university professors—I also rely on the International Standard Classification of Occupations (ISCO-08) to further identify individuals who are working as *associate and technical professionals, clerical support workers, service and sales workers*, or in *elementary occupations* within the previously selected caring industries. In this, I follow the formative work of Budig and Misra (2010), relying on both occupation and industry to specify my sample of care workers. My overall focus is thus on "lower-status" care workers, in employment conditions typically characterized by higher turnover rates and lower entry barriers, as compared to professional care work jobs (Barron and West 2013; Duffy 2011). Appendix Table A1 provides expanded details on the care work classification scheme used.

Variables of Interest

The dependent variables examine *who* engages in care work and capture any wage disadvantage associated with lower-status caring jobs. The main independent variables compare care workers to comparable nonprofessional individuals working in non-caring occupations, as well as comparing immigrants (defined here as people who were born outside of the country) to individuals born in the country.[1] Unfortunately, the LIS does not include consistent measures of respondents' race/ethnicity across national datasets.

In order to specify any particular care wage penalty, as well as capture any specific effect of being an immigrant worker, as many conceptually relevant control variables as are available across the datasets are included in the analysis. To account for the highly feminized nature of care work, a control for gender is included. Variables for family structure and demographic characteristics include a control for age, one for being married or cohabitating, and one for living with one's child aged 0–5 years. In addition, the potentially mediating effect of human capital is captured using educational attainment, relying on a categorical variable harmonized across countries. This variable has three categories: low (lower secondary education and less), medium (upper secondary education through to vocational post-secondary education), and high (university/college education and above). For the descriptive analyses, additional variables capturing the proportion of the care economy that is part-time, nonpermanent, self-employed, and in the private sector are also included where available. These variables attempt to encompass various aspects of nonstandard or precarious work within paid care (Lightman and Good Gingrich 2018; Vosko, Zukewich, and Cranford 2003).

An Overview of the National Care Economies

A descriptive overview of the care economy, by country, allows for initial examination of broad trends in care work both within and across care regime types. Table 2 profiles the care workforce in each country, providing the percentage of the overall workforce employed in caring jobs, as well as the percentage of the "lower-status" workforce employed in care (again, "lower status" is operationalized here as people working as associate professionals, clerical support workers, service and sales workers, or in elementary occupations). Table 2 also details the immigrant and female composition within care employment and the proportion of care workers engaged in "nonstandard" (e.g., part-time, nonpermanent, or self-employed) and private-sector employment. Mean percentages from the national data in each care regime are also provided in bold in all the tables, in order to assess broader similarities or differences. Upon examination of this data, clear trends within the care regimes are evident, reinforcing preliminary suggestions of the ongoing distinctiveness of each care regime type.

The percentage of the *entire* workforce (including both high- and low-status workers) that is employed in paid care varies considerably across countries and care regimes, from a low of 3.9 percent in Greece to a high of 14.5 percent in the Netherlands. The social democratic (14.1 percent) and corporatist (12.2) care regimes have the highest mean proportion of the entire workforce engaged in care, suggesting greater institutionalization of lower-status jobs in health, social work, education, and domestic services in these countries, and, potentially, relatively greater welfare state development. The liberal and familialistic care regimes, by contrast, and in particular Greece and Spain, have the lowest levels of worker participation in paid care, aligning with prior findings of high levels of informal care provisioning in southern European countries (Isakjee 2017). The second column in Table 2 focuses specifically on the *low-status* workforce, demonstrating that care comprises over a fifth of these workers at the mean level for the liberal, corporatist, and social democratic care regimes. In the Netherlands and the United States, care work comprises the highest proportion of the low-status workforce (at 30 and 28.9 percent, respectively), while in Greece and Spain, care work comprises less than 15 percent of lower-status workers, again suggesting that much of this care may be occurring within the gray sector or as unpaid family labor.

The data on the demographics of care workers is in line with existing intersectional research (e.g., Budig and Misra 2010; Folbre 2012; Lightman 2019) demonstrating the disproportionately feminized and immigrant/racialized composition of lower-status care work across countries and care regimes. In all countries examined, over three-quarters of the low-status care workforce is female. However, in examining the data on the immigrant composition of low-status care work, clear differences across care regimes are evident. In the social democratic regimes, immigrants make up a lower percentage of the care workforce than the total workforce (e.g., immigrants comprise 9.8 percent of

Table 2. Overview of the paid care economy (low-status work in health, education, social work, and domestic services) by country and care regime

	N	Percentage of total workforce	Percentage of low-status workforce	Percentage female	Percentage immigrant	Percentage part-time	Percentage nonpermanent /short-term	Percentage self-employed	Percentage in private sector
Regime type									
Liberal (mean)		**9.6**	**22.9**	**81.7**	**28.2**	**42.1**	**18.2**	**4.2**	**51.2**
AU (2014)	1494	9.0	27.1	81.2	30.5	58.8	NA	4.8	NA
CA (2010)	1237	8.0	14.3	79.1	36.0	41.5	15.2	3.6	37.6
CH (2013)	633	9.2	21.2	80.6	30.8	41.7	21.1	3.6	NA
US (2013)	7547	12.1	28.9	85.7	15.5	26.3	NA	4.7	64.7
Corporatist (mean)		**12.2**	**21.7**	**85.0**	**15.8**	**46.4**	**15.1**	**5.8**	**66.0**
AT (2013)	585	11.5	20	83.0	20.2	53.7	10.4	NA	79.9
DE (2013)	2105	15.3	26	85.0	14.1	43.8	19.8	5.8	55.6
FR (2010)	495	9.8	19.2	86.9	13.2	41.7	NA	NA	62.5
Familialistic (mean)		**6.9**	**13.2**	**79.2**	**13.4**	**19.9**	**22.3**	**NA**	**39.2**
ES (2013)	669	6.2	13.8	77.5	12.2	29.2	28.1	NA	NA
GR (2013)	239	3.9	9.5	78.7	6.0	8.8	16.1	NA	41.1
IT (2010)	651	10.7	16.3	81.4	22.1	21.7	22.8	NA	37.2
Social Democratic (mean)		**14.1**	**28.9**	**82.9**	**11.1**	**NA**	**NA**	**1.9**	**NA**
DK (2010)	9957	13.7	27.7	83.0	9.8	NA	NA	0.6	NA
NL (2013)	831	14.5	30.0	82.8	12.3	64.6	14.1	3.1	NA

Note: Population is limited to individuals aged 18–70 years, who are employed.

care workers in Denmark—as compared to 10.2 percent of the total workforce) despite having relatively large care economies. However, immigrants are overrepresented in care work (as compared to the total workforce) in the other three care regimes examined. In the liberal care regimes, immigrants make up over 30 percent of the care workforce in all countries except the United States. However, while the LIS data suggest that 15.5 percent of care workers in the United States are immigrants, this estimate is likely low, as it is worth noting that illegalized or undocumented workers are not included in most LIS data. Hayes and Hartmann (2017), for example, estimate that one in five immigrant direct care workers in the United States are undocumented. Thus, these findings align with Van Hooren's (2012) suggestion that liberal care regimes lead to a "migrant in the market" model of employment, while social democratic care regimes create no particular demand for migrant workers. Similar trends are found when the care workforce is disaggregated to analyze lower-status workers in education versus those in health, social work, and domestic services separately (see Appendix Tables A2 and A3).

Finally, examining the composition of the national care workforce engaged in "nonstandard" and private-sector employment, the data demonstrate that a higher proportion of care workers is part-time in the liberal and corporatist care regimes than in the familialistic care regime, while the reverse trend is found for nonpermanent or short-term work in care. This latter finding suggests that in Spain and Greece, while there are fewer paid care workers overall, those who do engage in these jobs are often employed only on a temporary or ad-hoc basis. Where data are available, the proportion of the care workforce reporting self-employment is higher in liberal and corporatist care regimes, and lower in the social democratic care regime, again suggesting greater institutionalization of the care workforce in the latter case. Finally, a higher percentage of care workers is employed in the private sector in the liberal and corporatist care regimes than in the familialistic regime. These findings, too, align with existing research, suggesting that countries without universal coverage for health and education have higher rates of nonstandard (precarious) employment in care, in part due to lower public investments and few worker protections (Van Hooren 2014).

Altogether, the initial descriptive statistics evidence both common trends and differences in the care economies within and across the four care regimes, with higher representation of immigrants and private-sector care workers found in the liberal and corporatist regimes. Figure 1 provides a visual representation of the proportion of females and immigrants working in care using pooled samples of workers within each care regime (with 95 percent confidence intervals applied). This figure, again, demonstrates significant variation across care regimes, but suggests that immigrants are more likely to work as "migrants in the market" within liberal or corporatist care regimes, and less likely to work in care within either the highly familialistic southern European care regime or the social democratic care regime, where public investments

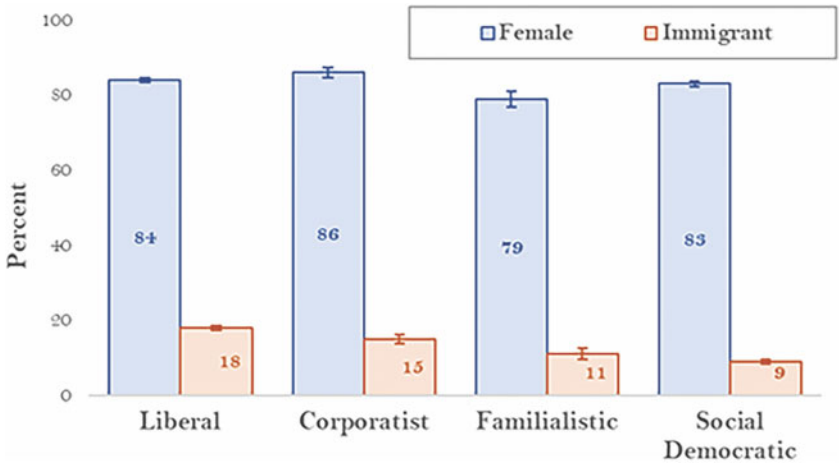

Figure 1 Percentage of female and immigrant workers in care work, by care regime

and collective agreements may "crowd out" demand for migrant workers in care (Van Hooren 2012).

Who Cares? The Probability of Performing Care Work

Table 3 uses multivariate analyses to examine who is engaged in lower-status care work within each country, and at mean levels for each regime type, again with the goal of examining similarities and/or differences across and within the care regime classifications. For this analysis, binary logistic regressions are run. Regression allows for examination of immigrant and gendered variation in care work, after statistically adjusting for family structure and demographic characteristics, as well as human capital. For these models, the dependent variables are dichotomously coded as 1 for employment in low-status care work, with 0 denoting all other "low-status" work (non-caring industries within the selected nonprofessional nonmanagerial occupations). For convenience in interpreting the results, the predicted probabilities are presented for each population group from the mean (e.g., their chances out of 100 of working in low-status care).

Table 3 demonstrates that in nine of the twelve countries examined immigrants have a higher probability of working in low-status care work than comparable non-immigrants. Thus, the results reinforce suggestions of the overrepresentation of migrant women in low-paying service jobs in health, education, and social work within the globalized care economy (Hochschild 2000; Parreñas 2013). In addition, while the magnitude of difference between immigrants and non-immigrants is minimal in certain cases, a clear pattern

Table 3. Chances out of 100 of performing low-status paid care work (for low-status workers) by country and care regime

	Liberal					Corporatist				Familialistic				Social Democratic		
	AU	CA	CH	US	Mean	AT	DE	FR	Mean	ES	GR	IT	Mean	DK	NL	Mean
Immigrants	25.5	12.3	19.2	24.9	**20.5**	18.3	24.3	15.1	**19.2**	11.8	7.4	9.2	**9.5**	28.2	27.5	**27.9**
Non-immigrants	26.6	10.6	12.1	24.0	**18.3**	15.6	23.1	10.8	**16.5**	13.9	8.8	12.8	**11.8**	24.5	26.4	**25.5**
Female	32.3	13.2	29.0	36.8	**27.8**	26.5	33.3	28.2	**29.3**	19.6	14.4	30.9	**21.6**	38.2	43.8	**41.0**
Male	15.2	6.8	9.5	11.1	**10.7**	8.6	11.4	5.4	**8.5**	6.4	3.7	4.2	**4.8**	11.6	11.6	**11.6**
Low education	28.7	12.8	25.3	31.5	**24.6**	25.1	26.0	15.4	**21.3**	11.4	10.8	7.1	**9.8**	25.6	29.3	**18.2**
Medium education	26.7	8.8	17.5	20.4	**18.4**	17.2	24.2	14.7	**18.7**	14.3	7.0	14.4	**11.9**	27.7	27.5	**27.6**
High education	18.7	8.0	16.0	18.3	**15.3**	16.7	20.8	12.2	**17.6**	10.7	3.0	4.6	**6.1**	16.2	20.2	**27.5**
N	5,330	8,643	2,896	29,816	**46,685**	2,850	7,720	2,499	**13,069**	4,693	2,430	3,032	**10,155**	35,268	2,481	**37,749**

Notes: Population is limited to individuals aged 18–70, who are employed, and have earnings >$0. Logistic regression results control for demographic characteristics (age, marital status/cohabitation, and the presence of young children in the household). Divided by 100, the product is a probability

emerges within care regimes. In the majority of liberal care regimes (all countries except Australia, where the focus for migration has disproportionately been on individuals with "high" skills (Hugo 2009)) immigrants have a higher probability of working in care than comparable non-immigrants, again reinforcing a "migrant in the market" model of employment. All countries within the corporatist care regime classification also demonstrate this same pattern of a higher probability of immigrants working in care than equivalent non-immigrants, suggesting that Austria, France, and Germany have care economies more similar to liberal care regimes than familialistic ones. Thus, in these countries, controlling for individual characteristics and human capital, migrant care workers disproportionately work in lower-status care work jobs.

Perhaps surprisingly, this same trend is seen within the social democratic care regimes. That is, immigrants in Denmark and the Netherlands have a higher probability of working in care than comparable non-immigrants. Given that Table 2 found comparatively lower representation of immigrants in care in this regime type, this suggests that education and demographic characteristics account for this higher probability of working in care. Thus, even where there is lower overall demand for immigrants working in care, once controls for individual characteristics and human capital are applied, immigrants are more likely than comparable non-immigrants to work in these low-status caring occupations within liberal, corporatist, *and* social democratic care regimes.

However, the reverse trend is found within the familialistic regimes. In Spain, France, and Italy, immigrants have a lower probability of working in health, education, social work, and domestic services than comparable non-immigrants, reinforcing the descriptive findings within these countries and suggesting substantive differences across care regimes, as well as potential access barriers to caring jobs for migrant workers within southern European countries, at least within the formal care economy. As noted previously, within these familialistic care regimes migrants may be working in care within the informal or gray economy and consequently not captured in the LIS data.

Immigrants have the highest probability of working in low-status care in Denmark (at 27.5 chances out of 100) and the lowest probability in Greece (at 7.4 chances out of 100) when the relevant controls are applied. In addition, as anticipated given the highly gendered nature of care, Table 3 demonstrates that in all countries women have considerably higher probabilities of working in low-status care than comparable men (more than seven times higher in Italy) and that compared to non-caring jobs, individuals in low-status care work are more likely to have a low or medium level of education, hinting again at lower wages and lower levels of social closure within these caring jobs than in comparable non-caring work.

Together, the logistic regressions in Table 3 demonstrate clear trends for immigrants and women across and within care regimes. As anticipated, in all cases women have a far higher probability of working in care than comparable men. In addition, in the majority of countries and across three care regimes,

immigrants have higher probability of working in low-status care than in other non-caring low-status occupations. Thus, here the data suggest a trend toward convergence across three care regimes among migrant care workers in the Global North.

The following section provides the final empirical analysis, measuring any overall wage penalty within care work using the pooled sample of all countries, while controlling for country-level variation and care regime type, using ordinary least squares regression.

Care Wage Penalties Across Care Regimes

Table 4 displays results from four pooled country models with country fixed effects to examine care wages in the total sample while controlling for gender, immigrant status, and care regime type. For these models, the dependent variable is the natural log of annual earnings (including wages and self-employment income), with values standardized across countries to 2013 USD. Logged earnings have the benefit of normalizing the earnings distribution, as well as allowing the transformed regression coefficients to be interpreted as approximate percentage change in earnings for a one-unit change in the independent variable.

Model 1 measures the effects of the focal individual-level variable only—employment in care work (as compared to working in a non-caring industry). Here, compared to non-care workers in equivalent lower status occupations, and in line with the previous findings on the financial devaluation of care (e.g., Barron and West 2013; England, Budig, and Folbre 2002), a 4 percent care wage penalty is found, controlling for country-level variation. Model 2 builds on Model 1, adding in the other focal variables of immigrant status, and gender—as well as controls for age of worker and its square, marital status, the presence of young children, and level of education. With the addition of these variables capturing individual characteristics and human capital, the care work wage penalty increases to 5 percent and the model fit increases substantively. In addition, women, overall, are found to incur a 36 percent wage penalty[2] as compared to men, and immigrants to incur a 14 percent wage penalty compared to non-immigrants. Thus, this pooled model predicts that a female immigrant care worker would have wages 55 percent lower (or less than half as large) as an equivalent male, non-immigrant working in a non-caring job. Given that Table 3 found that women have a far higher probability of working in care in all countries (and immigrants in the majority of countries), these findings suggest substantial wage disparities incurred by most care workers, as well as cumulative effects for migrants and women.

Next, Model 3 includes the country-level variable measuring care regime type (with "liberal" as the reference group). Here, controlling for regime type, the wage penalty for care work, immigrant status, and gender is largely

Table 4. Pooled country models predicting logged earnings among low-status workers (with country fixed effects)

	Model 1		Model 2		Model 3		Model 4	
	Coefficient	SE	Coefficient	SE	Coefficient	SE	Coefficient	SE
Intercept	10.09***	(0.01)	7.88***	(0.05)	7.88***	(0.05)	7.88***	(0.05)
Care work (ref = non-care employment)	**−0.04*** **	**(0.01)**	**−0.05*** **	**(0.01)**	**−0.05*** **	**(0.01)**	**−0.15*** **	**(0.03)**
Immigrant status (ref = non-immigrant)			−0.14***	(0.01)	−0.14***	(0.01)	−0.15***	(0.01)
Female (ref = male)			−0.36***	(0.01)	−0.36***	(0.01)	−0.38***	(0.01)
Immigrant × care work							−0.05	(0.03)
Female × care work							0.11***	(0.03)
Age			0.12***	(0.01)	0.12***	(0.01)	0.12***	(0.01)
Age squared			−0.01***	(0.00)	−0.01***	(0.00)	−0.01***	(0.00)
Married or cohabitating (ref = single/widowed/divorced)			0.07***	(0.01)	0.07***	(0.01)	0.07***	(0.01)
Living with child 0–5 years (ref = other)			0.06***	(0.01)	0.06***	(0.01)	0.06***	(0.01)
Education level (ref = high)								
Low			−0.67***	(0.02)	−0.68***	(0.02)	−0.68***	(0.02)
Medium			−0.37***	(0.01)	−0.38***	(0.01)	−0.38***	(0.01)
Care regime (ref = Liberal)								
Corporatist					−28***	(0.02)	−28***	(0.02)
Familialistic					−43***	(0.02)	−43***	(0.02)
Social Democratic					0.01	(0.03)	0.01	(0.03)
Statistical fit								
Adjusted R^2	0.05		0.25		0.27		0.27	
n (countries)	12							
N (individuals)	105,495							

Note: Population is limited to individuals aged 18–70 years, who are employed and have earnings >$0. ***$P < 0.001$.

unaffected, suggesting that the care wage penalty is not simply an artifice of being in a particular care regime. While, as anticipated, wages are overall lower in corporatist and familialistic care regimes, no significant difference is found for the social democratic care regime, as compared to the liberal care regime.

Finally, Model 4 adds an interaction between immigrant status and care work, as well as between gender and care work, to capture intersectional dynamics in care and examine any distinctive wage disparities experienced by immigrant or female care workers in particular. Here, the main effects demonstrate a continued wage penalty for immigrants and women not in care. However, the effect of care work (here assessed for males only) increases to 15 percent. As the interaction with care work and immigrant status is not significant, it is notable that no wage effect particular to being an immigrant in care work is found, controlling for the other factors. However, the data do demonstrate a significant and positive moderating effect of being female in care work (minimizing the care work wage disparity by 11 percent). Thus, this suggests that while immigrants have a higher probability of working in care than non-immigrants in most countries, male immigrants incur a wage penalty of 30 percent in care, on average, while female immigrants in care incur a 42 percent wage penalty due to both their gender and industry of employment (again compared to male non-immigrants working outside of care). In all models, robustness checks confirm the key results, as each model is run twelve times, dropping one country at a time to ensure the results are not driven by any particular country (i.e., remove-one jackknife).

As a final piece of evidence, Figure 2 presents the predicted mean earnings (again in 2013 USD) with 95 percent confidence intervals for workers inside

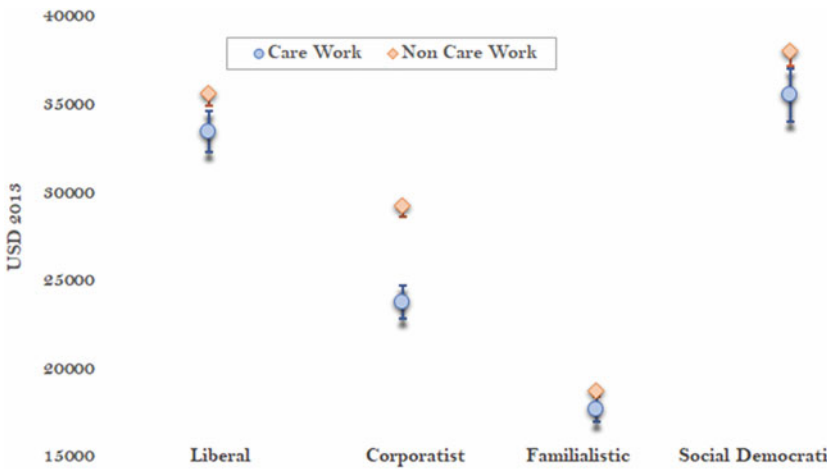

Figure 2 Predicted mean earnings in and out of care work (among low-status workers) within each care regime

and outside of care within the four pooled samples of care regimes (using the full model from Table 4 and holding all other variables at their mean). Overall wages are highest in the social democratic regimes and lowest in the familialistic regimes. Notably, significant differences between caring and non-caring work is found in the liberal, corporatist, and social democratic regimes.[3] The familialistic regime, by contrast, does not demonstrate a significant difference, suggesting less wage variation inside and outside of care, controlling for gender and immigrant status. Thus, in three of the four care regimes, the predicted earnings are significantly lower in care work than in non-care work, with the largest difference found in the corporatist regimes.

Taken together, Models 3 and 4 (Table 4) and Figure 2 demonstrate a care wage penalty independent of care regime and country-level variation, as well as an additional wage penalty for women and immigrants. However, after controlling for individual characteristics and human capital, no significant interactive wage effect of being a migrant within care work is found.

Limitations and Conclusions

Critics of a "care regime" approach note that there is often considerable variation in care provisioning across regime type, with the boundaries between regimes often unclear or blurred. Williams (2012), for examples, notes that difficulties often arise in measuring care economies due to unique national constellations in the role of the state, market, and family in providing care, variable policies used to recruit migrant workers, and "the casual and informal aspect of the work [which] hides those without approved credentials and attracts undocumented migrants whose numbers are difficult to assess" (365). Yet, at the same time, global trends toward the privatization of social services within wealthy Global North nations, and a growing free-market (and oftentimes anti-immigrant) orientation by governments mean that trends across care economies may well come to mirror those within liberal care regimes, ultimately leading to a cross-national care convergence toward a "migrant in the market" model of care provision.

The present study provided an initial effort to capture both differences and similarities across and within four care regimes, within the context of the increasing globalization of the care economy. In order to examine care work that is typically lower wage and often found to be precarious, the analysis focused specifically on lower-status caring jobs, excluding professional and managerial positions in health, social work, and education where there may be a "wage bonus" (Lightman 2017). At the descriptive level, and addressing my first research question, I found different trends across care regimes, in particular in terms of the proportion of immigrant and nonstandard workers. Countries in the liberal and corporatist care regimes demonstrate characteristics typical of the "migrant in the market" model of employment

(Van Hooren 2012), with higher rates of privatization in lower-status care work and more reliance on foreign-born women. The familialistic care regimes, by contrast, comprise a smaller proportion of the entire workforce (suggesting a higher reliance on familial forms of care or a larger informal care market), while the social democratic regimes have overall less of a reliance on migrant care workers.

Addressing my second research question, the multivariate analyses demonstrate similarities both within and across care regimes in terms of who is doing the work of care. In all countries examined women, not surprisingly, have a far higher probability of working in care than comparable men. In addition, in nine out of twelve countries examined, immigrants also have a higher probability of working in low-status care than equivalent non-immigrants. Thus, these results reinforce prior findings of the highly feminized (and racialized) nature of caring occupations with low levels of social closure (Barron and West 2013; Folbre 2012). However, the familialistic countries demonstrate an opposite trend, with immigrants having a lower probability of working in care than comparable non-immigrants (at least within the formal labor market). Thus, the results suggest variation across care regimes, as well as reinforcing ongoing suggestions of the distinctiveness of particular care economies.

Finally, in addressing my third research question, a significant care wage penalty (as well as a wage penalty for women and immigrants) is found even when controlling for country-level variation and care regime type. Thus, the devaluation of this highly feminized and racialized work is found to be a constant, independent of care regime or worker characteristics. While no additional wage penalty was found for immigrant care workers in particular, the cumulative effects of being an immigrant, a woman, *and* a care worker are found to result in a 42 percent wage penalty, as compared to a comparable male, non-immigrant, non-care worker. This hints at the intersectional dynamics at play and the multiple axes of disadvantage faced by many low-status workers.

Ultimately, findings from this article are meaningful in the current policy context. The data reinforce prior findings suggesting that countries where care provisioning is largely through private markets experience care work wage penalties and have a higher reliance on migrant and racialized women to provide low-status health and social services (e.g., Addati et al. 2018). However, the data also provide evidence of the devaluation of care work within countries with more expansive welfare states (e.g., in the social democratic care regimes) and suggest that many corporatist care regimes demonstrate characteristics typical of liberal care regimes under current conditions of neoliberal globalization.

Internationally, the contracting-out of low status care, in particular domiciliary services, nursing, childcare, and residential care, to the private-for-profit sector has seen a worsening of working conditions and labor shortages, in addition to reduced quality of recipient care (Cangiano and Walsh 2014;

Van Hooren 2014). Thus, growing government austerity and earnings polarization within and across care regimes coincide with global shifts toward market-oriented employment and immigration regimes (characteristic of the "migrant in the market" model) that disadvantage vulnerable (female, racialized) migrant care workers. This, ultimately, facilitates precarious working conditions for both immigrants and non-immigrants in care and has measurable effects on the quality of health, education, social work, and domestic services received by vulnerable populations.

Appendix

Table A1. Details of care work classification scheme, LIS, 2010–2014

Country, sample size, dataset	Care industries & occupations (derived from the International Standard Classification of Occupations (ISCO-08), and the LIS standardized industry variable)	
• Australia (AU) (N = 5,330) *Survey on Income and Housing* • Austria (AT) (N = 2,850) *Survey on Income and Living Conditions* • Canada (CA) (N = 8,643) *Survey of Labour and Income Dynamics* • Denmark (DK) (N = 35,268) *Law Model (based on administrative records)* • France (FR) (N = 2,499) *Household Budget Survey* • Germany (DE) (N =7,720)	• Industries = education, human health activities, residential care activities, social work activities, domestic activities in private households • Occupations = technicians and associate professionals, clerical support workers, service and sales workers & elementary occupations	
	Education – examples of included occupations: • Teaching associate professionals; child care workers; babysitters; nannies; teachers' aides	*Health, social work, domestic care – examples of included occupations* • Health associate professionals; personal care workers in health services; health care assistants; birth assistants; psychiatric aides; home-based personal care workers; dental aides; hospital orderlies; pharmacy aides; first aid attendants; domestic housekeepers

Continued

Country, sample size, dataset	Care industries & occupations (derived from the International Standard Classification of Occupations (ISCO-08), and the LIS standardized industry variable)
German Socio-Economic Pane • Greece (GR) ($N = 2,430$) *Survey on Income and Living Conditions* • Ireland (IL) ($N = 3,438$) *Survey on Income and Living Conditions* • Italy (IT) ($N = 3,071$) *Survey of Household Income and Wealth* • Netherlands (NL) ($N = 2,131$) *Survey on Income and Living Conditions* • Spain (ES) ($N = 4,693$) *Survey on Income and Living Conditions* • Switzerland (CH) ($N = 2,896$) *Survey on Income and Living Conditions* • United States (US) ($N = 29, 816$) *Current Population Survey—Annual Social and Economic Supplement)*	

Table A2. Overview of the paid care economy: low-status work in education by country

	N	Percentage of total workforce	Percentage of low-status workforce	Percentage female	Percentage immigrant	Percentage part-time	Percentage nonpermanent/ short-term	Percentage self-employed	Percentage private sector
Regime type									
Liberal (mean)		**2.1**	**5.1**	**74.7**	**22.7**	**44.3**	**19.2**	**4.4**	**15.8**
AU (2014)	365	2.2	6.6	85.9	21.9	60.5	N/A	7.3	N/A
CA (2010)	463	2.5	5.0	72.4	33.5	44.1	21.3	1.3	9.5
CH (2013)	100	1.3	3.1	59.2	24.1	36.5	17.0	8.0	N/A
US (2013)	1,493	2.4	5.7	81.3	11.1	36.1	N/A	1.1	22.0
Corporatist (mean)		**2.6**	**4.8**	**84.7**	**16.9**	**50.8**	**17.8**	**2.4**	**40.2**
AT (2013)	112	2.2	3.8	76.5	12.8	62.8	12.9	N/A	63.6
DE (2013)	422	2.9	5.0	85.4	15.1	53.2	22.7	4.8	35.6
FR (2010)	154	2.8	5.5	92.2	22.7	36.4	N/A	0	21.4
Familialistic (mean)		**2.8**	**5.4**	**78.5**	**4.7**	**23.2**	**25.5**	**N/A**	**28.2**
ES (2013)	169	1.5	3.4	80.3	4.2	50.0	36.0	N/A	N/A
GR (2013)	35	0.5	1.2	75.3	7.6	8.3	20.5	N/A	45.9
IT (2010)	422	6.4	11.5	80.0	2.4	11.3	20.1	N/A	10.4
Social Democratic (mean)		**3.2**	**6.4**	**72.3**	**12.7**	**53.3**	**14.9**	**N/A**	**N/A**
DK (2010)	3,445	4.8	9.6	75.3	9.7	N/A	N/A	N/A	N/A
NL (2013)	89	1.5	3.2	69.2	15.6	53.3	14.9	N/A	N/A

Note: Population is limited to individuals aged 18–70 years, who are employed.

Table A3. Overview of the paid care economy: low-status work in health, social work, and domestic services by country

	N	Percentage of total workforce	Percentage of low-status workforce	Percentage female	Percentage immigrant	Percentage part-time	Percentage nonpermanent/ short-term	Percentage self-employed	Percentage private sector
Regime type									
Liberal (mean)		**7.5**	**17.8**	**83.7**	**29.9**	**40.8**	**10.7**	**4.0**	**66.1**
AU (2014)	1,129	6.8	20.5	79.8	33.2	57.0	N/A	4.0	N/A
CA (2010)	774	5.5	9.3	83.7	37.9	39.6	11.1	3.5	56.8
CH (2013)	533	7.9	18.1	84.2	31.9	42.6	10.2	2.8	N/A
US (2013)	6,054	9.7	23.2	86.9	16.6	23.8	N/A	5.6	75.3
Corporatist (mean)		**9.6**	**17.0**	**84.7**	**15.1**	**45.1**	**13.8**	**3.9**	**74.3**
AT (2013)	379	9.3	16.2	84.5	22	50.3	8.6	N/A	83.7
DE (2013)	1,618	12.4	21.0	84.9	13.9	41.5	19.0	6.0	60.4
FR (2010)	341	7.0	13.7	84.7	9.4	43.6	N/A	1.8	78.8
Familialistic (mean)		**4.1**	**7.8**	**80.1**	**24.0**	**22.7**	**23.0**	**N/A**	**58.6**
ES (2013)	500	4.7	10.4	76.6	14.9	22.3	25.3	N/A	N/A
GR (2013)	204	3.4	8.3	80.1	5.8	8.9	16.7	N/A	40.4
IT (2010)	229	4.3	4.8	83.5	51.3	37.0	26.9	N/A	76.7
Social Democratic (mean)		**8.9**	**22.2**	**85.7**	**10.9**	**65.9**	**14.0**	**N/A**	**N/A**
DK (2010)	6,512	8.9	17.6	87.0	9.8	N/A	N/A	N/A	N/A
NL (2013)	742	13.o	26.8	84.4	11.9	65.9	14.0	N.A	N/A

Note: Population is limited to individuals aged 18–70 years, who are employed.

Notes

Naomi Lightman is Assistant Professor of Sociology at the University of Calgary. Her areas of research expertise include migration, gender, inequality, and research methodology. Her academic work has been published in journals including *European Sociological Review*, *Journal of European Social Policy*, and *International Migration Review*. In addition, she is the co-author of the second edition of the textbook *Social Policy in Canada*.

1. The immigration variable in the Canadian dataset only includes individuals who live in an urban area of 500,000 persons or more.
2. This gender differential is likely explained, in part, by women's higher levels of part-time and precarious employment, variables unavailable in the LIS across countries.
3. While this figure demonstrates higher earnings overall in liberal and social democratic regimes, it does not adjust for variations in cost of living in each country/care regime.

Funding

This work was supported by a Social Sciences and Humanities Research Council of Canada Insight Development Grant (File no: 430-2018-00062).

References

Addati, Laura, Umberto Cattaneo, Valeria Esquivel, and Isabel Valarino. 2018. *Care work and care jobs for the future of decent work*. Geneva, Switzerland: International Labour Organization (ILO).

Albertini, Marco. 2014. Support to the elderly and caring regimes: An analysis of patterns of informal support and their determinants in six European countries. In *The transformation of care in European societies*, ed. Margarita León, 134–57. Basingstoke: Palgrave Macmillan.

Anderson, Bridget, and Isabel Shutes. 2014. *Migration and care labour: Theory, policy and politics*. Basingstoke: Palgrave Macmillan.

Banerjee, Rupa, Philip Kelly, Ethel Tungohan, Petronila Cleto, Conely de Leon, Mila Garcia, Marco Luciano, Cynthia Palmaria, and Chris Sorio. 2018. From "Migrant" to "Citizen": Labor Market Integration of Former Live-In Caregivers in Canada. *International Labour Review* 71 (4): 908–936.

Barron, David N., and Elizabeth West. 2013. The financial costs of caring in the British labour market: Is there a wage penalty for workers in caring occupations? *British Journal of Industrial Relations* 51 (1): 104–23

Blofield, Merike, and Juliana Martínez Franzoni. 2014. Maternalism, co-responsibility, and social equity: a typology of work-family policies. *Social Politics: International Studies in Gender, State & Society* 22 (1): 38–59.

Boucher, Anna Katherine. 2019. How 'skill' definition affects the diversity of skilled immigration policies. *Journal of Ethnic and Migration Studies* 1–18.

Brennan, Deborah, Bettina Cass, Susan Himmelweit, and Marta Szebehely. 2012. The marketisation of care: Rationales and consequences in Nordic and liberal care regimes. *Journal of European Social Policy* 22 (4): 377–91.

Budig, Michelle J, and Joya Misra. 2010. How care-work employment shapes earnings in cross-national perspective. *International Labour Review* 149 (4): 441–60.

Cangiano, Alessio, and Kieran Walsh. 2014. Recruitment processes and immigration regulations: the disjointed pathways to employing migrant carers in ageing societies. *Work, Employment & Society* 28 (3): 372–89.

Cortez, Nathan. 2008. International health care convergence: The benefits and burdens of market-driven standardization. *Wisconsin International Law Journal* 26 (3): 646.

Da Roit, Barbara, and Bernhard Weicht. 2013. Migrant care work and care, migration and employment regimes: A fuzzy-set analysis. *Journal of European Social Policy* 23 (5): 469–86.

Duffy, Mignon. 2011. *Making care count: A century of gender, race, and paid care work*. New Brunswick, NJ: Rutgers University Press.

Duffy, Mignon, Randy Albelda, and Clare Hammonds. 2013. Counting care work: The empirical and policy applications of care theory. *Social Problems* 60 (2): 145–67.

Duffy, Mignon, and Amy Armenia. 2019. Paid care work around the globe: A comparative analysis of 47 countries prepared for UN women. LIS Cross-National Data Center in Luxembourg.

Elrick, Jennifer, and Naomi Lightman. 2016. Sorting or shaping? The gendered economic outcomes of immigration policy in Canada. *International Migration Review* 50 (2): 352–84.

England, Paula, Michelle Budig, and Nancy Folbre. 2002. Wages of virtue: The relative pay of care work. *Social Problems* 49 (4): 455–73.

Esping-Anderson, Gøsta. 1990. *The three worlds of welfare capitalism*. New York, NY: Princeton University Press.

Eydal, Guðný Björk, and Tine Rostgaard. 2016. *Fatherhood in the Nordic welfare states: Comparing care policies and practice*. Bristol: Policy Press.

Fagertun, Anette. 2017. Localising globalisation: Gendered transformations of work in emergent economies. *Journal of Development Studies* 53 (3): 311–15.

Folbre, Nancy, ed. 2012. *For love or money: Care provision in the United States*. New York, NY: Russell Sage Foundation.

Hayes, Jeffrey, and Heidi Hartmann. 2017. The growing need for home care workers: Improving a low-paid, female-dominated occupation and the conditions of its immigrant workers. *Public Policy & Aging Report* 27 (3): 88–95.

Hellgren, Zenia. 2015. Markets, regimes, and the role of stakeholders: Explaining precariousness of migrant domestic/care workers in different institutional frameworks. *Social Politics: International Studies in Gender, State & Society* 22 (2): 220–41.

Hochschild, Arlie Russell. 2000. Global care chains and emotional surplus value. In *On the edge: Living with global capitalism*, ed. Will Hutton and Anthony Giddens, 130–46. London: Jonathan Cape.

Hugo, Graeme. 2009. Care worker migration, Australia and development. *Population, Space and Place* 15 (2): 189–203.

Isakjee, Arshad. 2017. Welfare state regimes: A literature review. IRiS Working Paper Series, University of Birmingham.

Jensen, Perh, and Henrik Lolle. 2013. The fragmented welfare state: Explaining local variations in services for older people. *Journal of Social Policy* 42 (02): 349–70.

Jokela, Merita. 2019. Patterns of precarious employment in a female-dominated sector in five welfare states—The case of paid domestic labor sector. *Social Politics: International Studies in Gender, State & Society* 26 (1): 30–58.

Kilkey, Majella, Helma Lutz, and Ewa Palenga-Möllenbeck. 2010. Introduction: Domestic and care work at the intersection of welfare, gender and migration regimes: Some European experiences. *Social Policy and Society* 9 (03): 379–84.

King-Dejardin, Amelita. 2019. The social construction of migrant care work at the intersection of care, migration and gender. In *International Labour Organization Report 978-92-2-132864-3*.

León, Margarita. 2016. *The transformation of care in European societies*. New York, NY: Springer.

Lightman, Naomi. 2017. Discounted labour? Disaggregating care work in comparative perspective. *International Labour Review* 156 (2): 243–67.

——— 2019. The migrant in the market: Care penalties and immigration in eight liberal welfare regimes. *Journal of European Social Policy* 29 (2): 182–96.

Lightman, Naomi, and Luann Good Gingrich. 2018. Measuring economic exclusion for racialized minorities, immigrants and women in Canada: Results from 2000 and 2010. *Journal of Poverty* 22 (5): 398–420.

Lightman, Naomi, and Anthony Kevins. 2019. Bonus or burden? Care work, inequality, and job satisfaction in eighteen European countries. *European Sociological Review* 35 (6): 825–44.

Lombardo, Emanuela. 2017. Austerity politics and feminist struggles in Spain: Reconfiguring the gender regime? In *Gender and the economic crisis in Europe*, ed. Johannah Kantola and Emanuela Lombardo, 209–30. Cham, Switzerland: Palgrave Macmillan.

Lutz, Helma. 2017. Care as a fictitious commodity: Reflections on the intersections of migration, gender and care regimes. *Migration Studies* 5 (3): 356–68.

Misra, Joya, and Stephanie Moller. 2005. Famililism and Welfare Regimes: Poverty, Employment, and Family Policies. LIS Working Paper Series.

Misra, Joya, Jonathan Woodring, and Sabine N. Merz 2006. The globalization of care work: Neoliberal economic restructuring and migration policy. *Globalizations* 3 (3): 317–32.

Parreñas, Rhacel Salazar. 2013. Transnational mothering: A source of gender conflict in the family. In *Migration, Familie und soziale Lage*, ed. Thomas Geisen, Tobias Studer, and Erol Yildiz, 169–94. New York, NY: Springer.

Ranci, Costanzo, Marta Cordini, Stefania Cerea, and Marco Arlotti. 2019. Migrant and/or care workers? Debating the ethnicization of the elderly care market in Italy and the United Kingdom. *Social Politics: International Studies in Gender, State & Society*. doi: 10.1093/sp/jxz002.

Rostgaard, Tine. 2014. Nordic care and care work in the public service model of Denmark: Ideational factors of change. In *The transformation of care in European societies*, 182–207. New York: Springer.

Schober, Pia S. 2014. Day care trends for children under three years in Germany. In *The transformation of care in European societies*, 208–32. New York: Springer.

Sharma, Nandita Rani. 2006. *Home economics: Nationalism and the making of 'migrant workers' in Canada*. Toronto, Canada: University of Toronto Press.

Shire, Karen. 2015. Family supports and insecure work: The politics of household service employment in conservative welfare regimes. *Social Politics: International Studies in Gender, State & Society* 22 (2): 193–219.

Tungohan, Ethel. 2018. Living with compromised legal status: Irregular temporary foreign workers in Alberta and the importance of imagining, strategizing, and interprovincial legal consciousness. *International Migration* 56 (6): 207–20.

Van Hooren, Franca. 2012. Varieties of migrant care work: Comparing patterns of migrant labour in social care. *Journal of European Social Policy* 22 (2): 133–47.

——— 2014. Migrant care work in Europe: Variety and institutional determinants. In *The transformation of care in European societies*, ed. Margarita Leon, 62–82. Basingstoke: Palgrave MacMillan.

Vosko, Leah F, Nancy Zukewich, and Cynthia Cranford. 2003. Precarious jobs: A new typology of employment. *Perspectives on Labour and Income* 4 (10): 16–26.

Weedon, Kim A. 2002. Why do some occupations pay more than others? Social closure and earnings inequality in the United States. *American Journal of Sociology* 108 (1): 55–101.

Williams, Fiona. 2012. Converging variations in migrant care work in Europe. *Journal of European Social Policy* 22 (4): 363–76.

Williams, Fiona, and Anna Gavanas. 2008. The intersection of childcare regimes and migration regimes: A three-country study. In *Migration and domestic work: A European perspective on a global theme*, ed. Helma Lutz, 13–28. London: Routledge.