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Migrant Live-In Care Workers in the Global Care Chain: Results From an Online Survey

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Abstract

High-income countries are using migrant care workers to address deficiencies in domestic care, thereby creating new care gaps in their countries of origin. Apart from this, care workers often face challenging working conditions in many countries. This article examines the job profile, needs, and training preferences of migrant live-in care workers in Austria to inform improvements to their working and living conditions. As part of a transdisciplinary project, an online survey was co-designed with live-in care workers and CSOs working with care workers. The survey covered four languages (Slovak, Romanian, Bulgarian, and German). Themes included job profile, training requirements, problems encountered, well-being, health, work breaks, and social contact in Austria. Descriptive analysis was applied using key figures, including mean values and frequency distributions. The results were interpreted by the project team. Two hundred and twenty-five live-in care workers completed the survey. The study found that live-in carers perform numerous additional tasks, some of which make them feel uncomfortable. Some live-in carers reported experiencing sexual harassment and physical violence, as well as a deterioration in their physical and mental health, since starting work as a live-in carer. Participants expressed substantial interest in training opportunities, particularly those dealing with difficult situations in the household. There is great potential to improve conditions for live-in care workers in Austria by providing services in their native languages. This would benefit both live-in care workers and care recipients and their families. The expectations regarding what live-in carers are and are not allowed to do should be communicated much more clearly to clients and their families. Furthermore, dependency on brokering agencies could be reduced by introducing a public health official responsible for administering live-in arrangements as part of official home care in Austria.

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Keywords
care crisis; communication; community care; family carers; home care; long-term care; migration

1. Introduction

The European population is living longer. By 2050, the proportion of Europeans aged 85 and over is expected to increase by 6.1% (compared to 2.7% in 2019; Eurocarers, 2023). At the same time, the number of family carers (mostly women) providing long-term care at home without financial compensation is decreasing for a variety of reasons. More women are in employment today, leaving them with less time for family care, although in most cases it is still women who perform that work. Men are not doing significantly more care and household work than before. Additionally, state services for older people and children are not adequately addressing the care gap (Aulenbacher et al., 2024; Dowling, 2022). One strategy adopted by many high-income countries is to recruit migrant care workers to address the care crisis (Aulenbacher et al., 2024; Hanrieder & Janauschek, 2025; Lan, 2022).

The "global care chain" approach, originally framed by Ehrenreich and Hochschild (2003) and Parreñas (2001) and later applied to Europe by Lutz and Palenga-Möllenbeck (2015b), has been used to theorise this phenomenon of outsourcing global reproductive labour. This approach analyses how richer countries take advantage of migrant labourers (mostly women) from poorer countries who are looking for better opportunities.

One example of women migrating to work in care is adult care, and more specifically live-in care. Live-in care is a prime example of the global care chain. Since 2010, prominent scholars have discussed live-in care in German-speaking countries, particularly focusing on the migration of Eastern European citizens to Germany, Austria, and Switzerland. The discussion has centred on the German–Polish context (Lutz & Palenga-Möllenbeck, 2015a; Palenga-Möllenbeck, 2014), the Austrian context featuring examples from Slovakia and Romania (Aulenbacher et al., 2020; Aulenbacher, Lutz, & Schwiter, 2021), and the Swiss context featuring examples from Slovakia (Schilliger et al., 2023; Schwiter et al., 2018). These sociologists have focused particularly on the macro and meso levels, examining how national regimes of gender, migration, and care organise live-in care as a short-term solution to long-term care organisation in high-income countries. They have also investigated the exploitation of migrant care workers, who are predominantly women from Eastern Europe and Asia. Studies demonstrate the impact of austerity measures in the public sector on care quality. Nevertheless, the system continues to function due to the exploitation of migrant live-in care workers (Aulenbacher et al., 2024; Schilliger et al., 2023). The studies also focus on the meso level, referring to informal and formal networks and organisations. These entities link families, live-in care workers, and the country of destination. In the live-in care sector, the most important of these entities are brokering agencies. A study of the practices of such agencies has revealed that live-in workers often have very precarious "just-in-time" work contracts that have been negotiated by the agency rather than by the worker herself. Due to their precarious employment status, live-in carers often lack access to social benefits in the countries where they are employed (Schilliger et al., 2023).

Other studies focus on the micro-level of organising life between two countries, which migrant care workers have to navigate. These studies adopt an agency perspective, focusing less on how women from the Global

South or East are victims of exploitation by the Global North, and more on how they are active agents in their own lives. These studies also challenge some of the structural barriers they face (Christensen & Guldvik, 2016; Ivanova, 2022; Palenga-Möllenbeck, 2014). For example, they focus on the personal motivations of women who migrate as care workers. These studies focus on transnational family life and the active negotiation of class, migration, and gender in countries of residence and employment. It has been demonstrated that many live-in carers do not come from the poorest sections of society (Ivanova, 2022). Rather, they perceive their employment as a live-in carer as an opportunity to achieve a specific goal, such as financing a house or their children's further education (Ivanova, 2022). Another motivation for women, typically in their 50s or 60s, to engage in paid care work is often the low pensions in their countries of origin (Lutz & Palenga-Möllenbeck, 2015a). Fewer studies have focused on the relationship between migrant caregivers and care receivers. Those that do exist show that the expectations of clients and care workers are often unrealistic, leading to frustration on both sides (Ayalon, 2009, 2011). Other studies have shown that the relationship between live-in carers and clients, as well as between carers and agencies, is characterised by a significant power imbalance, where dominance and control over migrant live-in carers is justified by attributing ethnic or racial characteristics to the women carers (Lewicki & Probst, 2026; Prieler, 2021).

1.1. Context: Live-In Care in the Long-Term Care Sector in Austria

A phenomenon that is gaining in popularity in Austria is live-in care, where a carer lives with the person they are caring for. Home care in Austria also depends on migrant care workers. Lay care personnel work in shifts of two to four weeks (or longer) to provide care to older adults in their homes. By the end of 2024, Austria had 56,836 live-in care workers, as well as over 1,000 brokering agencies (Wirtschaftskammer Österreich, 2025).

Austria's long-term care sector is organised around a familialist logic, whereby family members are responsible for the care needs of other family members (Aulenbacher, Lutz, & Schwiter, 2021; Österle, 2012; Trukeschitz et al., 2022). There is a seven-step care allowance scheme whereby, depending on how many hours of care a person needs, they receive a cash benefit directly from the state government. This cash benefit can then be used to organise personalised care (Eurocarers, 2023; Famira-Mühlberger, 2017). Over 5% of all care allowance recipients use live-in care arrangements (Aulenbacher, Leiblfinger, & Prieler, 2021; Aulenbacher & Prieler, 2024). The majority (95%) of the live-in carers are women aged between 41 and 60 from Romania (55%), Slovakia (22%), Croatia (6%), Hungary (6%), Bulgaria (3%), Austria (2%), and other countries. These women commute between Austria and their countries of origin. Working conditions are precarious, with communication difficulties within families, excessive working hours, and often no breaks at all (Geserick, 2021; Wirtschaftskammer Österreich, 2025). Another factor contributing to precarity is that live-in carers are self-employed, yet they depend heavily on agencies to negotiate contracts with families. They also require significant support to navigate the bureaucracy of self-employment due to language barriers and transnational complexities (Aulenbacher, Lutz, & Schwiter, 2021; Aulenbacher & Prieler, 2024).

Studies on the job profiles, job satisfaction, or working conditions of live-in care workers are scarce and tend to focus more generally on long-term care. An EU-wide study found that long-term care workers felt they were not paid adequately more often than other healthcare workers, particularly in non-residential care, of which live-in care is a part (Eurofund, 2020). Long-term care workers also rated work intensity as higher and the social environment as more challenging than other workers. One possible explanation for this is that the work is emotionally demanding, as these workers regularly visit people in need of care (e.g., people with dementia) in

their own homes. This can be emotionally rewarding, but also challenging (Bauer et al., 2018; Eurofund, 2020). A study of Austria found that many long-term care workers were dissatisfied with their working conditions, although the scores were often better for home care than residential care (Bauer et al., 2018). These studies generally focused on long-term care workers in residential and home care settings, but it is unclear whether live-in care workers were included.

There is a lack of more specific studies on the working conditions or job satisfaction of live-in care workers in Austria. This is a highly precarious group of workers that is often overlooked in the home care sector. No measures to improve their particular working conditions can be found in everyday local or national welfare politics. This demonstrates the high level of marginalisation of this group, which consists almost entirely of migrant women from Eastern European countries—a group that is often discriminated against in Austria and Western Europe. Lewicki and Probst (2026) speak of a "gendered racialisation as 'Eastern European'" (p. 41), and Prieler (2021, p. 483) speaks of an ethnicisation in Austrian live-in care, producing imaginaries of women from Eastern European countries that justify their control and exploitation in the care labour market. Clients, agencies, and even live-in care workers themselves often attribute qualities such as willingness to work hard or flexibility to certain ethnicities. This makes it easier to justify live-in carers having no regular work breaks or performing more tasks than agreed in the contract (Prieler, 2021):

> Brokering agencies advertise live-in workers as quasi-members of the family, highlighting their dedication and flexibility as well as their cultural and social similarity to the people they care for. Care workers themselves emphasise their physical and psychological resilience. Within all these (self-)constructions of the "good live-in care worker," ethnicisation processes take place, for instance with regard to migrants' special caring capacities or conflicts attributed to supposed differences in mentality. (Prieler, 2021, p. 484)

This study focuses on the job profiles and working conditions of live-in care workers in Austria. By job profile, we refer to the tasks performed by live-in care workers in households, and how these tasks overlap with the formal characteristics of the job itself. What are the workers' own perspectives on the job, and what are their training needs and wishes regarding live-in care?

1.2. Aim

The survey that forms the basis of this article aimed to examine the working and living conditions of migrant live-in care workers in Austria. The research question was: "What are the perceptions of migrant live-in care workers regarding their working and living conditions in Austria?" The survey was part of a larger participatory action research project, MigraCare: Integrating 24-Hour Live-In Care Workers in Austrian Care Networks, which aimed to better integrate live-in care workers into existing care networks in Austria, as well as design possible training programmes for the workers based on their specific needs. The survey was intended to inform the design of these training programmes. Based on the survey, several short videos and webinars were created for live-in care workers.

2. Methods

2.1. Study Design

Our article is based on a survey conducted as part of a participatory action research project, which included live-in carers and CSOs that work closely with live-in care workers, for example by providing consultation on their rights and political lobbying for the rights of migrant live-in care workers. The survey focuses on the job profile, subjective health conditions, wishes, and training needs of live-in care workers. It was conducted as part of the MigraCare project, which aimed to integrate 24-hour live-in care workers into Austrian care networks. The project was funded by the Ludwig Boltzmann Gesellschaft and ran from January 2023 to December 2024. The project aimed to better integrate live-in carers into Austrian care networks, with each project partner having different responsibilities. The project consortium consisted of a transdisciplinary group of research institutions (Medical University of Vienna and SYNYO GmbH); a CSO representing the rights of migrant live-in care workers in Austria (Initiative for Justice in Personal Care in Austria [IG24]); one live-in carer; a CSO that runs a project for live-in care workers (CuraFair Volkshilfe Upper Austria); and a volunteer organisation for live-in carers in Austria (BetreuerinnenCafé, an initiative offering coffee breaks where live-in carers can socialise, enjoy some free time, and speak in their mother tongues). The Medical University of Vienna coordinated the project; SYNYO GmbH was responsible for the survey; IG24 was responsible for networking, lobbying, and connecting with community nurse services, as well as disseminating the survey to live-in carers and designing and organising further training in the carers' mother tongues; and CuraFair Volkshilfe Upper Austria was responsible for scaling up the BetreuerinnenCafés in collaboration with the volunteer organisation, as well as disseminating the survey to live-in carers. The project consortium met online once a month to discuss project tasks and general sector developments. Several of these meetings were dedicated to designing the survey and discussing its results. During the project's kick-off meeting, the consortium discussed whether to use qualitative methods (online or telephone interviews) to reach live-in carers and find out about their working situations and training needs, or quantitative methods (a survey). The CSOs, who work closely with live-in carers (IG24 and CuraFair), and the live-in carer in the project consortium considered that an online survey would be better, as it would not take much time to complete, and time was the scarcest resource for live-in carers. They could also complete it from anywhere. They also found that it would be easier to reach more live-in carers with the survey. Also, as IG24 lobbies the Austrian government on behalf of migrant live-in carers, they found it would be easier to use survey results than interview results to inform political lobbying.

2.1.1. Online-Survey

To gain insight into the working and living conditions of live-in carers and record their needs, the project consortium developed a 45-question questionnaire (see the Supplementary File for the full questionnaire in English). Data were collected over a period of two months (15/07/2023–15/09/2023). Participation was voluntary and anonymous. Live-in carers were directly involved in developing the questionnaire within the project consortium. Topic areas were selected based on the expertise of the practice partners in several rounds. Researchers then designed a first draft of the questionnaire. This was discussed in detail with the project consortium, with the questions being adapted to make them as understandable as possible for live-in carers. The online survey was created using Google Forms and stored in Excel files. It covered demographic data, education, job profile, training requirements, problems experienced, well-being, health, and working

hours/breaks. Most questions had pre-defined answers (multiple choice or single), but there was also an option to provide a free answer. To make it accessible to a large group of live-in carers, the questionnaire was translated into Romanian and Slovak by native speaker members of the project consortium. In addition, another project member gave the questionnaire to a Bulgarian friend, who translated it into Bulgarian, in order to reach an even larger group of carers. According to statistics, there are 1,692 Bulgarian live-in carers in Austria, which is a small group, but still accounts for 3% of the overall total (Wirtschaftskammer Österreich, 2025). The responses to the questionnaire were translated using Google Translate and checked by the native speakers who had translated the questionnaire.

2.1.2. Recruitment

Participants were recruited using a purposive sampling strategy. To ensure relevance to the research context, the study specifically targeted women working as live-in carers in Austria who originated from Romanian-, Slovak-, and Bulgarian-speaking countries, as these groups represent the majority of live-in carers in Austria. The questionnaire was distributed by project team members through various social media networks used by these communities, primarily WhatsApp groups and Facebook pages. To maximise outreach, the practice partners also posted short explanatory videos containing the survey link.

2.1.3. Data Analysis

The descriptive analyses relate to all quantifiable survey variables. These include key statistical measures, such as mean values and frequency distributions, which are complemented by graphical representations. Excel was chosen due to the manageable size of the dataset. We considered grouping the data by language or age, but only minor differences were found between subgroups. We explored the variables for potential demographic effects, but found no substantial differences. As we only performed descriptive statistics, we applied deletion to missing data. It was appropriate to remove variables with missing values as the amount of missing data was small, which is why n differs between each variable/question.

Following data collection, preliminary findings were discussed and contextualised in group sessions involving the research team and practice partners. This process was not intended to replace formal statistical inference, but rather to inform the interpretation of results in light of the contextual knowledge of practitioners and live-in carers. This interpretive component aligns with the principles of participatory research, adding depth to the descriptive findings (Ramsden et al., 2010). Several online project consortium meetings were held to discuss the survey findings, as well as which of these could be developed into further training for live-in carers. During the project, the 2007 Austrian National Public Health Institute (Gesundheit Österreich GmbH) produced short videos on various topics for live-in carers in multiple languages, which coincided with the results of our survey. The Austrian National Public Health Institute had been in contact with IG24 who advised them on the topics, also based on our survey results. Consequently, the project consortium decided to allocate project resources to a video on sexual harassment in the workplace. Although sexual harassment at work was not a main topic of the survey, the CSOs knew it was an issue for many live-in carers, and our project was flexible enough to adapt the resources to address this issue.

2.2. Ethics

The study has a positive vote of the Ethics Board of the Medical University of Vienna (1595/2023).

3. Results

In this section, we will present the results of the live-in care survey, beginning with the respondents' demographic data, training and job profile, performance of nursing and medical tasks, training needs, well-being and health, and working hours and breaks. A total of 225 live-in carers took part in the survey. Table 1 shows the distribution of respondents by language: 49% of the surveys were answered in Slovak, 44% in Romanian, 6% in Bulgarian, and 2% in German. Official figures indicate that the majority of live-in carers are Romanian (55%) and Slovak (22%), followed by Hungarian, Croatian, and Bulgarian (3%), and Austrian (2%) nationals. Therefore, our sample is overrepresented by Slovak-speaking live-in carers. This is due to the composition of our project consortium, which included two Slovak native speakers, as well as the organisation IG24, which has many Slovak members. The vast majority of participants were women (97%), with an average age of 54 years.

Table 1. Respondents' demographics.

Respondents' demographics (n = 225)	%
Gender	
Women	97%
Men	3%
Divers	0%
Language (of survey completion)	
Slovak	49%
Romanian	44%
Bulgarian	6%
German	2%
Age (in years)	
31–40	5%
41–50	20%
51–60	63%
61–70	12%

3.1. Training and Job Profile

3.1.1. Training

One question asked, "Do you have professional training in caregiving, nursing, or the medical field?" Two hundred and eighteen out of a total of two hundred and twenty-five respondents answered this question. While 29% of respondents stated that they had no training in care, nursing, or the medical field, 69% indicated that they had some kind of professional training in care or nursing. Respondents could fill in a free-text field to explain what kind of training or job qualifications they had, who organised the programme,

and in which country. The most frequently cited training programmes were care courses, geriatric care, nursing, and home help. Twenty participants indicated that they had received training as qualified nurses. Most participants indicated that they had completed their training in their home countries, such as Bulgaria, Romania, and Slovakia. However, Austria, Germany, and Italy were also mentioned as training locations.

3.1.2. Job Profile

On average, the respondents in our sample had 10 years' experience working as live-in carers. Of the respondents, 46% stated that they had worked as a caregiver in a country other than Austria, while 54% had only worked in Austria (total response rate: *n* = 217/225). We asked the live-in carers to indicate the tasks they carry out at work. First, they indicated the tasks officially listed in government documents, such as preparing meals, running errands, keeping company, and assisting with daily routines (total response rate: *n* = 222/225; see Figure 1).

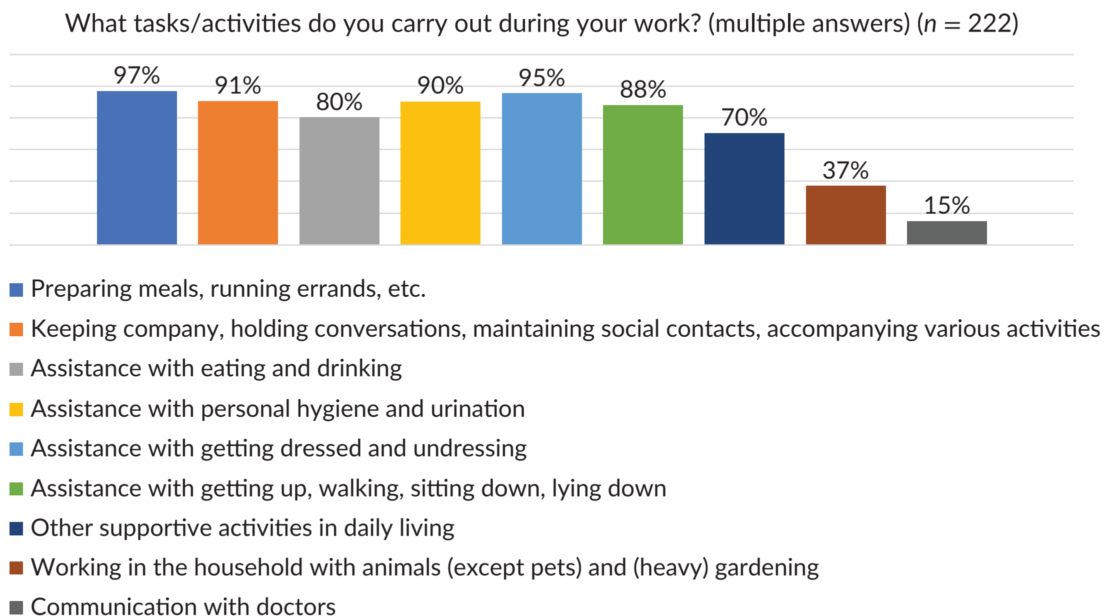

Figure 1. Work tasks.

Additionally, responses from the free-text field indicate that many respondents perform tasks that extend beyond the official job description defined by the Ministry of Health (BMSGPK, 2021). Examples often cited include cooking for relatives (children and grandchildren), looking after more than one person (not agreed in the contract), and performing manicures and pedicures.

3.1.3. Unpleasant Tasks

We also asked if there were any tasks that made them feel uncomfortable (total response rate: *n* = 213/225): 43% answered "yes" and 56% answered "no." Many respondents listed situations in the free-text field, for example, "cleaning clients after death." Many stated that they care for people with dementia or Alzheimer's and are often confronted with their aggression. Some carers indicated that they often feel uncomfortable in conflict situations with family members, partly due to a perceived lack of respect from the family towards

them. Some carers also reported experiencing physical and psychological violence, as well as sexual harassment. These examples illustrate the extent to which live-in carers frequently encounter precarious circumstances. Additional issues identified include permanent control by the family, bullying by one family member, and disrespectful treatment. These responses suggest that live-in carers need access to independent institutions that can support them in cases of harassment and physical assault. Furthermore, these institutions should provide clear guidelines on permitted actions and circumstances in which refusal is to be exercised.

3.2. Nursing and Medical Tasks

We also asked whether live-in carers were performing nursing or medical tasks. Of those who responded to the question, “Do you carry out nursing tasks?” ($n = 212/225$), 57% said yes, 8% said “I don’t know,” and 34% said no. According to official guidelines, live-in carers are not permitted to undertake any nursing or medical tasks, except when delegated to do so by qualified healthcare professionals, such as doctors or nurses (BMSGPK, 2021). A doctor or qualified nurse must provide training and confirmation of the carer’s training. While family carers would be allowed to perform any tasks, live-in carers are not permitted to do so, even if instructed by family caregivers (with the only exception being if live-in carers were qualified and registered as nurses according to the Austrian Nursing Act (Bundeskanzleramt der Republik Österreich, 2026a). In our survey, 20 respondents indicated that they were qualified nurses. The answers regarding medical tasks are comparable: Although live-in carers in Austria are officially only supposed to perform medical tasks in exceptional circumstances, 201 out of 225 participants indicated that they carry out medical tasks (see Figure 2). Ninety-two percent of participants stated that they administered medication; 39% applied and changed dressings; and 30% carried out simple light and heat applications. Twenty-two percent were responsible for administering subcutaneous insulin and anticoagulant injections. Seventeen

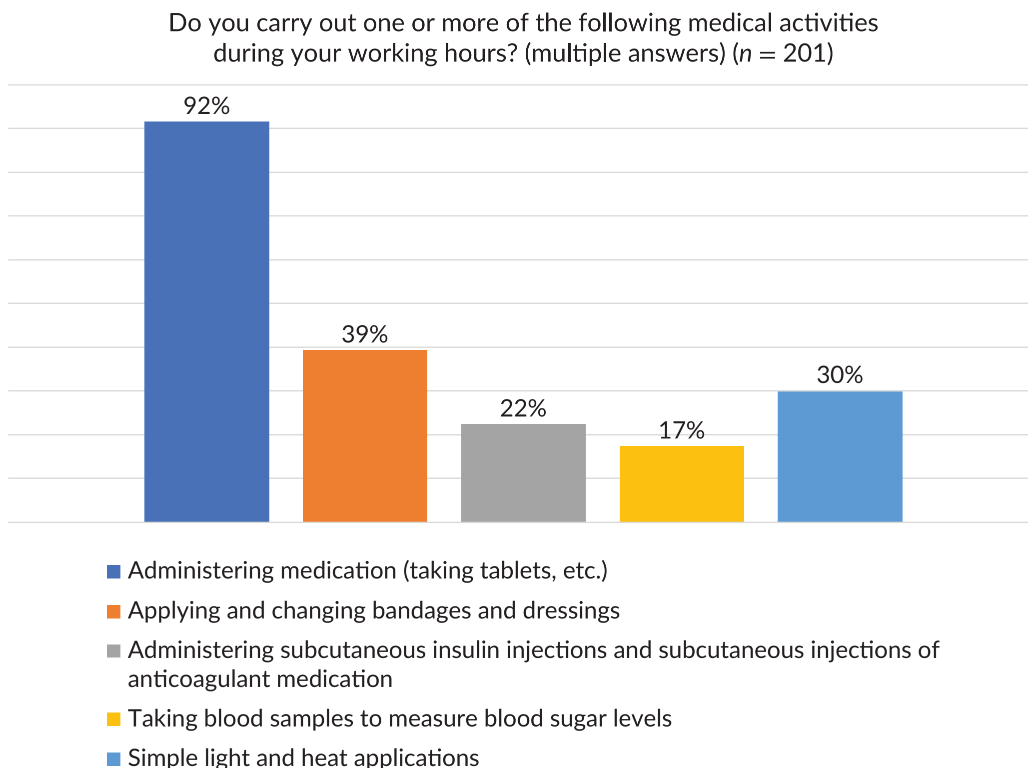

Figure 2. Medical tasks.

percent stated that they took blood samples to measure blood glucose levels. Respondents also had the opportunity to provide additional answers. Additional nursing and medical tasks mentioned by individual carers included feeding patients with tracheostomies or percutaneous endoscopic gastrostomy (PEG) tubes, administering morphine, treating burns and applying decubitus dressings, and insulin injections.

Free-text answers to the question "What tasks do you carry out during your work?" also suggest that the distinction between care and nursing is blurred in daily practice. The following quotes illustrate this: "Taking a urine sample," "handling medication," "the physiotherapist showed me exercises that my client could do at home with my help and support." It is often difficult for both the carer and the client to make the distinction between care and nursing.

3.3. Training Needs

The survey results show that live-in carers want further education and training. Of the 202 respondents to this question, 76% want to learn about specific activities, 61% want to learn how to handle challenging caregiving situations, 40% want to learn how to respond to a client's sudden health deterioration, and 39% want to learn what to do when a patient dies (see Figure 3).

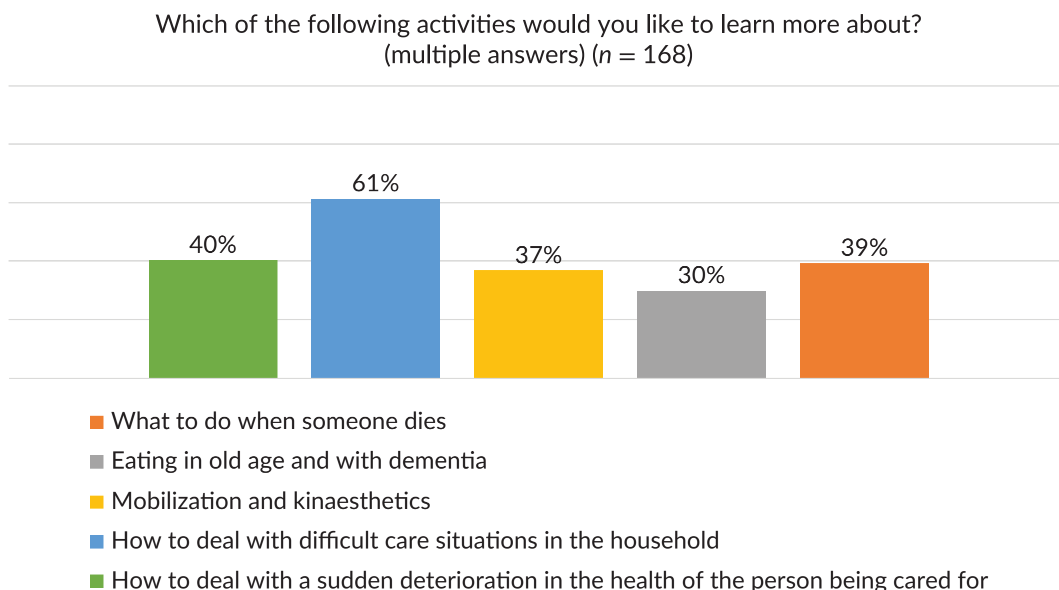

Figure 3. Further training needs.

We then asked, "Which labour law issues would you like to know more about?" (multiple answers possible), offering 15 possible answers. The total response rate was 194/225. Sixty percent (n = 116) of respondents said they wanted to learn more about "how to deal with conflict situations concerning legal regulations with the care recipient." Fifty-eight percent (n = 112) wanted to know more about their "rights and obligations towards the care recipient's family," and 56% (n = 108) wanted to know more about the "duties of a live-in carer." This final response highlights the ambiguity that characterises the role of a live-in carer.

We also asked which topics they would like short videos on, with multiple answers possible (total response rate: 195/225). Respondents mostly wanted videos on bureaucratic topics, such as an explanation of

pension insurance (50%) and questions about contracts between agencies and clients (49%), or on the topic of dementia (42%). Additionally, 27% wanted a video on "sexual harassment in the workplace," which, together with some free-text answers about unpleasant tasks (see Section 2.1), indicates that sexual harassment is an issue for live-in carers.

3.4. Well-Being and Health

In terms of well-being and health, the survey shows that a significant proportion of respondents, namely 64%, report suffering from back pain. Around a third of respondents reported exhaustion (37%) or joint pain (31%). Around 28% of respondents indicated that they suffer from mental health problems. Within this group, 11% cited depression and 17% cited burnout as stressful factors (see Figure 4). Other physical impairments listed by carers in the free-response section were Crohn's disease, a damaged spinal cord, sciatica, sleep problems, and work frustration due to the overall care system. The majority of respondents (78%) stated that these issues had worsened since they started working as live-in carers (see Figure 5). Data on the social aspects of carers in Austria shed light on their personal perceptions and social interactions. While half of the respondents (50%) did not report feelings of isolation or loneliness, a significant proportion (46%) reported experiencing loneliness in Austria. The study's findings indicate that live-in care workers require further training and support with regard to their physical and mental health. It is recommended that they should not be left to deal with the health issues of their clients as well as their own.

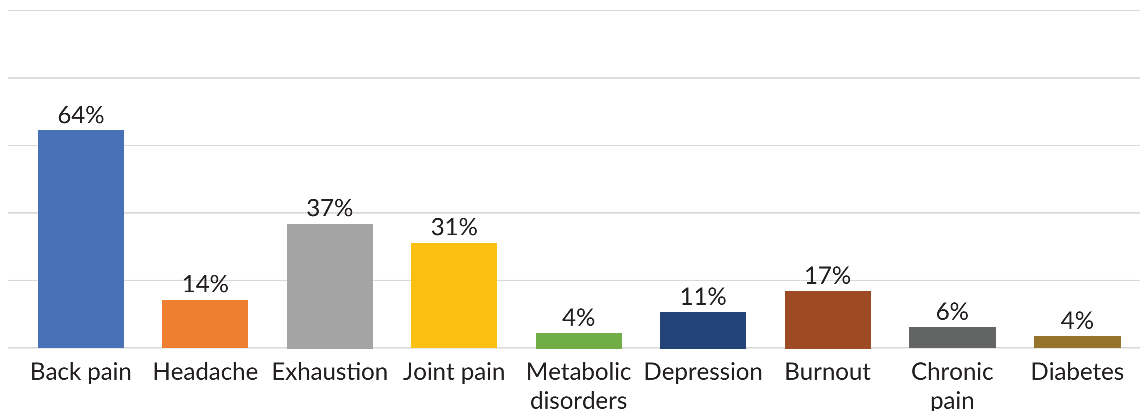

Figure 4. Health of live-in carers.

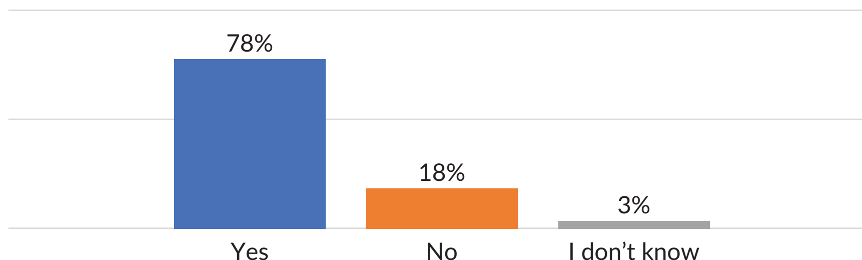

Figure 5. Deterioration of health.

3.5. Work Breaks

Data on work breaks show that live-in carers take an average break of around 1.5 hours (ranging from 0 to 4.5 hours) per 24-hour period. Thirty-one percent state that they do not have breaks during which they are not required to be present (see Figure 6). According to Article §3(2) of the Home Care Act, live-in carers are supposed to have a minimum three-hour break during which their presence is not required (Bundeskanzleramt der Republik Österreich, 2026b).

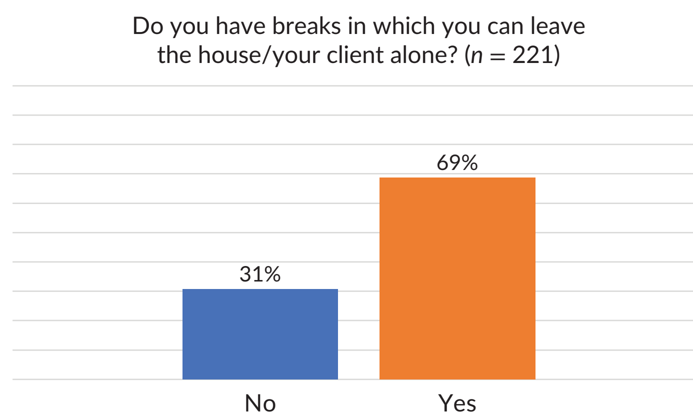

Figure 6. Work breaks.

The client's needs and the level of family support available also play a role. Whether live-in carers are required during breaks depends on various factors, including the availability of the care recipient and their family. Respondents emphasised the significant variations and unregulated nature of work breaks in private households, which are often negotiated by agencies rather than workers.

4. Discussion

This study focuses on the working and living conditions of migrant live-in care workers in Austria. Unlike other studies, which focus on the overall structural problems of live-in care work—crucial for improving the organisation of home care—this study focuses on the job profile and the wishes and needs of migrant live-in carers. The results of the survey indicate that most live-in carers perform tasks that go beyond their official job description. These tasks are challenging and range from nursing and medical duties to caring for multiple clients (not specified in the contract), manicures and pedicures, and dealing with harassment and violence (often due to dementia). The study shows that live-in care workers in Austria need training and support to help them cope with their duties, and to protect themselves against harassment and violence from clients or their families. The poor mental and physical health of many respondents highlights the need for this support.

4.1. Experiences of Discrimination and the Relationship With Clients and Their Families

The survey results highlight a number of issues relating to the relationships between live-in carers, their clients, and the clients' family members. These include perceived disrespect, harassment and violence, and a desire for guidance on managing conflict with clients. Although harassment or violence were not the focus of the study, they were often mentioned in the free-text answers, for example in relation to unpleasant

tasks. A recent study (2024) conducted in Austria among live-in carers showed that 45% of respondents (n = 1,417) had experienced violence at work, confirming that this is a problem in live-in arrangements (Mairhuber et al., 2024). Additionally, our survey touches upon the matter of inadequate or absent work breaks. The findings of this study are corroborated by the results of other research conducted on migrant care workers, which frequently demonstrates that said workers are confronted with racist and sexist prejudices (Boris & Parreñas, 2010; Christensen & Guldvik, 2016). Lutz and Palenga-Möllenbeck (2015a) state that Polish live-in carers are often seen as "natural and good carers" in Germany. Similarly, workers from the Philippines are often seen as the "good Asian migrant" who becomes part of the family, as depicted in the works of Ayalon (2009, 2022) and Spiliopoulos and Cuban (2025). However, it is important to note that these stereotypes facilitate the exploitation of care workers (Gerhards et al., 2022; Green & Ayalon, 2018). This is due to the suggestion that caring is an innate ability rather than a professional skill. Furthermore, it is implied that people in this profession are likely to carry out tasks outside their job description or working hours due to a perceived familial bond.

As most of our respondents undertake tasks that are not part of the official live-in care job profile, including unpleasant tasks, it is likely that other reasons are involved besides a lack of knowledge about what they are allowed/supposed to do. Research in Germany, Austria, and Switzerland analysed discourses on live-in carers. The results show that a "good carer" is often expected to be naturally devoted to older people and willing to provide round-the-clock care, viewing it as a moral obligation rather than a job (Bachinger, 2015; Lutz, 2011; Prieler, 2021). Research shows that these characteristics are often attributed to women, and in the context of live-in care, to women from Eastern European countries. Age also plays a role: As these women are often over 50, other characteristics are emphasised, such as "motherliness and life experience" (Prieler, 2021, p. 487). Prieler (2021) analyses how such discourses justify the dominance and control of migrant live-in care workers, attributing qualities such as a willingness to work hard or flexibility in working hours to a certain ethnicity, for example. By attributing such qualities to a certain ethnicity, power relations and coercion (e.g., between an agency and a live-in worker) are downplayed (Lewicki & Probst, 2026; Prieler, 2021).

Research from Germany and Israel also indicates that clients and family members frequently have unrealistic expectations of live-in care work, leading to disappointment for everyone involved (Ayalon, 2011; Gerhards et al., 2022; Green & Ayalon, 2018). Better management of these expectations could foster mutual support. Both the studies from Gerhards et al. (2022) and Green and Ayalon (2018) emphasise the unrealistic expectations that families have of live-in workers. These workers are expected to fulfil the roles of service provider, nursing professional, family member, and moral agent, providing support to those in need (Cohen-Mansfield & Golander, 2023). A study from Israel by Cohen-Mansfield and Golander (2023) shows that respect and appreciation are important for the satisfaction of live-in carers. A study from Germany (Gerhards et al., 2022) also found that family members often assign nursing and medical responsibilities to live-in carers, such as administering medication to clients. Our results support this, showing that live-in carers regularly perform nursing and medical tasks, even though these are not part of their official job description (BMSGPK, 2021). It is important that both live-in carers and the families of clients are better informed about which tasks live-in carers are and are not allowed to perform, especially to avoid consequences for live-in carers who would be held accountable if something were to happen to the client.

4.2. Deskilling of Live-In Care Workers

Many studies of migrant care workers in the global care chain demonstrate how these workers experience deskilling in their destination countries. Cuban (2013) and Raghuram and Kofman (2004), for example, describe how deskilling affects migrant care workers, whether they are unskilled or highly skilled, often due to training qualifications that are not recognised in the destination country, as well as experiences of gendered and racialised discrimination. This combination of factors often results in women ending up in low-status, low-paid employment in the care sector. This is evidenced by Spiliopoulos and Cuban's (2025) research on Filipino nurses and Wojczewski et al.'s (2015) findings on nurses and doctors in sub-Saharan Africa. There is evidence of deskilling in live-in care work in Austria, as articulated in Cuban's work (2013): Some live-in carers in our study have university degrees or qualifications in healthcare or nursing, yet now work in a job where no qualifications are required or remunerated accordingly. In our survey, for example, 20 respondents indicated that they were qualified nurses, yet they work as live-in carers, where those qualifications, though often necessary, are not remunerated accordingly.

However, a more general deskilling of the group has also been observed. In our survey, many respondents said that they frequently undertake nursing and medical tasks on behalf of their clients. However, they are not paid accordingly, and society does not recognise this as professional care work. Furthermore, as nursing and medical tasks can only be performed under the supervision of a doctor or nurse, live-in carers sometimes perform illegal tasks, which puts them in a precarious situation with possible legal repercussions. Nevertheless, clients and family members often ask live-in carers to perform such tasks.

The reasons why live-in carers still accept jobs where they face deskilling can be found by looking at their personal motivations. The migrant carers are often over 50, or even over 60, as shown by our sample. Most live-in carers in Austria are probably not looking to develop or build a career, but rather to fulfil another personal goal, such as increasing their low pensions, paying off mortgages, or funding the education of their grown-up children. Similar motivations have been observed among Bulgarian women working as live-in carers in Italy, known locally as *badanti* (Ivanova, 2022), and among Polish live-in carers in Germany, as described by Palenga-Möllenbeck (2014). However, Prieler's (2021) research also shows that many carers are dedicated to their work, feel they can make a real difference to clients and families, want to try something new in their lives, and enjoy getting to know another country.

4.3. Needs for Training and Support for Live-In Carers

Our survey shows that live-in care workers are highly interested in improving their knowledge and skills in various areas. The job profile for live-in carers should be revised to reflect real-life working conditions (BMSGPK, 2021). More visits by healthcare professionals would be useful for assessing the needs of live-in carers and clients, and for helping with tasks that live-in carers are not permitted to perform. It would also be useful if these visits were used to check that work breaks are being taken. As our results show that nursing and medical tasks are not uncommon, mandatory training and adequate remuneration should also be provided for performing those tasks in home care. Training and support should be provided in the workers' native languages. Our results show that live-in carers are interested in further information and training on caring for people with dementia or Alzheimer's disease, communicating with clients and family members, and understanding job responsibilities. The live-in carer (as well as their client) should also be more familiar with legal themes such as

the Home Care Act (Bundeskanzleramt der Republik Österreich, 2026b), which regulates live-in care in Austria, and its implications for all affected groups, as well as the role of brokering agencies.

The results show that training alone is insufficient and that live-in carers require additional support, both institutional and informal. Many experience health problems, sexual harassment, and violence, and feel isolated in Austria. This suggests that official representation by the Chamber of Commerce is insufficient; representation by the Chamber of Workers (Arbeiterkammer) could be beneficial, as it specifically advocates for workers' rights and has experience with many of the issues that live-in carers face. In other countries, such as Italy, where there are many Ukrainian live-in carers, their informal organisation is stronger, partly because they work longer shifts and stay in the country of residence for longer. Ivanova's (2022) ethnographic study shows that live-in carers meet on a specific day and in a specific place informally, to chat and exchange experiences. This would be unthinkable in Austria, where many live-in carers do not even know where to find others. This form of self-organisation could be very helpful, as live-in carers could meet and exchange information without interference from the local population. In order for such an informal network to develop, live-in carers must be granted regular and regulated work breaks.

4.4. Strengths and Limitations

The survey of migrant live-in carers in Austria covers a wide range of topics. It was translated into the most widely spoken languages within this group. We used a participatory design approach, in which the survey was designed and interpreted by researchers and live-in care workers, who have first-hand experience of the situation and its challenges. One limitation is that the questions about the education profile of live-in carers were not formulated very precisely. Participants' open answers about their nursing and care training and qualifications varied widely, making interpretation difficult. We could not recruit more than 225 participants, which may be due to the length of the questionnaire (more than 40 questions) and the fact that it was only available online for two months. However, it should be noted that live-in care workers are generally difficult to reach due to their vulnerabilities, such as their dependency on agencies and clients. In light of this, the number of respondents can be considered a good result. Although sexual harassment was mentioned in the survey, particularly in the free-text answers, it would have been useful to include direct questions about experiences of sexual harassment. To compensate for this, we added another survey conducted in Austria to the discussion (see Mairhuber et al., 2024).

5. Conclusion

The current situation with regard to home care in Austria, particularly live-in arrangements, requires improvement. While the promotion of independent living for as long as possible is a prevalent practice in Austria's care regime (and in many other countries), the question remains: How can such arrangements be organised fairly for everyone involved? This study is the first to explore the job profile, job satisfaction, and desires of live-in carers. Our study shows that migrant live-in carers urgently need training and support to fulfil their roles, as well as protection against harassment and violence. This support should be both formal and informal. Clients and their families should be made aware of what they can reasonably expect from a live-in carer. In general, dependency on brokering agencies should be minimised, and an independent public health body should regularly check live-in situations. Communities of live-in care workers should also meet regularly to exchange ideas.

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Conflict of Interests

The authors declare no conflict of interests.

Data Availability

Anonymised data are available upon request to the corresponding author.

LLMs Disclosure

During the preparation and review of this work, the authors used a licensed version of DeepL to improve the language and readability of the text. Having used this tool, the authors reviewed and edited the content as required, taking full responsibility for the publication's content.

Supplementary Material

Supplementary material for this article is available online in the format provided by the authors (unedited).

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