

cogitatio

SOCIAL INCLUSION

Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe

Volume 14

2026

Open Access Journal

ISSN: 2183-2803

Edited by Ewa Palenga-Möllenbeck, Dora Gabriel, Olena Fedyuk, and Kristine Krause

Social Inclusion, 2026, Volume 14
Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe

Published by Cogitatio Press
Rua Fialho de Almeida 14, 2º Esq.,
1070–129 Lisbon
Portugal

Design by Typografia®
http://www.typografia.pt/en/

Cover image: © Viktor Nemeth

Academic Editors
Ewa Palenga-Möllenbeck (Goethe University Frankfurt)
Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies)
Olena Fedyuk (CEU Democracy Institute)
Kristine Krause (University of Amsterdam)

Available online at: www.cogitatiopress.com/socialinclusion

This issue is licensed under a Creative Commons Attribution 4.0 International License (CC BY). Articles may be reproduced provided that credit is given to the original and *Social Inclusion* is acknowledged as the original venue of publication.

Table of Contents

Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe
Ewa Palenga-Möllenbeck, Dóra Gábriel, Olena Fedyuk, and Kristine Krause

Migrant Live-In Care Workers in the Global Care Chain: Results From an Online Survey
Silvia Wojczewski, Simona Ďurišová, Sabine Pleschberger, Anna Ernst, Rojin Bagheri, Kathryn Hoffmann, and Viktoria Adler

Selling Care Skills? The Multiple Meanings of Training for Polish Live-In Care Workers in Germany
Roxana Fiebig-Spindler

The Invisible Hand of Care: A Typology of Brokerage Actors in Migrant Care Labour
Ewa Palenga-Möllenbeck, Ivanna Kyliushyk, and Roxana Fiebig-Spindler

Care Extractivism Beyond Households: Migration and Care for Older People in the Post-Yugoslav Semi-Periphery
Majda Hrženjak

Caring Communities in Urban Hungary: A Civil Society Perspective
Dóra Gábriel, Bettina Török, and Noémi Katona

Care Under Constraint: Unmet Care Needs Among Older Adults in Romania
Mihaela Hărăguș and Ionuț Földes

Skill Construction and Challenges of Professionalization in the Hungarian Home Care Market
Noémi Katona and Dóra Gábriel

The Right to Care and Support: From Care Theory to Human Rights Law
Maroš Matiaško

Senior Care in Wartime Ukraine: A Fragmented Continuum of Arrangements Inside an "Unpromising Sector"
Oksana Dutchak, Olena Fedyuk, and Anna Oksiutovych

Bounded Transport, Mobility Justice, and Claims for Recognition Among Live-in Care Workers
Petra Ezzeddine

In Times of the Market and Community Shift: On Live-In Care and Caring Communities
Brigitte Aulenbacher, Klaus Wegleitner, Jonas Hagedorn, and Bernhard Emunds

Table of Contents

Care Outsourcing From Germany to Central and Eastern Europe
Kristine Krause, Veronika Prieler, Hanna Horváth, Matouš Jelínek, Mariusz Sapieha, Zuzana Sekeráková Búriková, Petra Ezzeddine, and Luise Schurian-Dąbrowska

Imagining Care: Transnational Inequality and Older Age Prospects for Ukrainian Caregivers in Italy
Oksana Dutchak, Olena Fedyuk, and Anna Oksiutovych

The Winding Road to Professionalisation: Care Work in Romanian Nursing Homes
Neda Deneva, Ionuț Földes, Denisa Ursu, and Mihaela Hărăguş

The Limits of State Control in Regulating Live-In Care Work in The Netherlands
Siënna Hernandez, Kristína Bartošová, and Franca van Hooren

Home Care for Sale: Marketisation and Social Change
Attila Melegh

Social Inclusion
2026 • Volume 14 • Article 13078
https://doi.org/10.17645/si.13078

cogitatio

EDITORIAL

Open Access Journal

Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe

Ewa Palenga-Möllenbeck [1], Dóra Gábriel [2], Olena Fedyuk [3], and Kristine Krause [4]

[1] Institute of Sociology, Goethe University Frankfurt, Germany
[2] ELTE Centre for Social Sciences, Hungary
[3] CEU Democracy Institute, Hungary
[4] Department of Anthropology, University of Amsterdam, The Netherlands

Correspondence: Ewa Palenga-Möllenbeck (epalenga@uni-frankfurt.de)

Submitted: 27 July 2026 **Published:** 3 September 2026

Issue: This editorial is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dóra Gábriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

This thematic issue explores the complex processes and outcomes of transnational care economies in Central and Eastern Europe. It shifts the analytical gaze to this region, foregrounding silences around care gaps, the emergence of new actors alongside largely indifferent welfare states, dynamics of professionalization and precarization, and the entanglements of paid and unpaid work within families and communities. The contributions trace movements from, to, and within Ukraine, Poland, the Czech Republic, Slovakia, Hungary, Romania, Bosnia and Herzegovina, Slovenia, Austria, Germany, Italy, and the Netherlands. In addition, the issue asks how sustainable mobile care is and considers future scenarios of senior care in Europe.

Keywords

Central and Eastern Europe; intersectionality; knowledge co-production; marketization and professionalization of care; migration and mobility; senior care; social politics and policies; transnational care chains; war

1. Introduction

The story of transnational care migration from Central and Eastern Europe (CEE) is far from new. What emerged after the fall of the Iron Curtain as a temporary opportunity for many women who had lost their

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

jobs in the post-socialist transition and convenient personalized care for older adults in Western and Southern Europe has since proved to be not only a persistent arrangement, but one that has now transformed care, labour, and mobility regimes throughout Europe. Far from disappearing, the model of migrant-in-the-family or migrant-in-the-care system has expanded to incorporate growing numbers of actors and agents, institutions and legal frameworks that have enabled, complicated, and solidified what was essentially rooted in transnational care chains relying on economic inequality and gendered work, and results in care and skill gaps in certain regions while privileging others (Katona & Melegh, 2020). Far from erasing or even out these inequalities and gaps (Lutz, 2025), emerging regimes of care and mobility legalize and normalize the extraction of care and labour, formalizing, monetarizing, and marketizing them according to the logics of labour extraction, outsourcing costs onto the workers, and monetarizing the logic of care (Aulenbacher et al., 2024; Farris & Marchetti, 2017).

This thematic issue aims to capture the new amorphous situation and the dynamics that are currently shaping care and mobility in CEE, giving new roles to the region and repositioning the various actors involved in organizing transnational care, and to reflect the lessons to be drawn from the trends, developments and changes we observe. It foregrounds thinking from the CEE region, rather than from regions that have traditionally been at the receiving end of care migration.

Turning the gaze eastwards is timely. This collection appears at a time of "multiple crises" and social change (Melegh, 2026), including the situation of an ongoing war, in which, paradoxically, care work is more needed than ever, yet is continually rendered invisible, pushed aside, or neglected by what has been termed the "cannibalistic nature of capitalism" (Fraser, 2022). During the Covid-19 pandemic, restrictions on the mobility of care workers in Europe briefly highlighted the instability of the care mobility model, which is characteristic of CEE (Ezzeddine & Uhde, 2025). At the same time, the pandemic also highlighted the reliance on these models and the neglect of this sphere from the point of view of more sustainable solutions. The pandemic brought out the deeply rooted historical, structural and symbolic asymmetry in the region, based on intersectional and transnational inequalities (Lutz, 2025) and "peripheral whiteness" (Safuta, 2018). In many national discourses of both sending and receiving countries, the needs of domestic care workers were rendered invisible, downplaying the risk and cost to the workers, while the need of older people and their families for care was rendered a purchasable commodity (Palenga-Möllenbeck, 2024).

This collection consequently paints a bigger picture of transnational care mobilities as interconnected vessels: the independence of some people is based on the dependency of others. Geopolitical extractivism, externalization of societies, and the invisibilization of care needs shape the field not only in the context of crises such as Covid-19 or the direct effects of war (Dutchak et al., 2026a) and the resulting humanitarian and military priorities, but also in everyday practice. It approaches the current situation as the outcome of historical, longitudinal societal ignorance and neglect by various actors (states, care providers) and of a persistent refusal to find long-term, heuristic solutions for senior care work, a "profitable sector," as Dutchak et al. (2026a) and Krause et al. (2026) characterize it.

Our approach is to look not just at migration or care work per se. In a more comprehensive approach, we focus on transformations of decent care and care work, the transnationalization of institutions, the mobility of persons in need of care, and the mobilization of care workers for their rights. Importantly, we investigate the perspectives of various actors shaping and benefiting from care mobility (older citizens, care workers, family

members, entrepreneurs) as well as emerging institutions that are enabling and increasingly regulating mobility and care (transportation, work placement agencies, training companies, small and large corporations providing care facilities). We also take into account the views of care users (older citizens and their families) and mobile workers who materialize care through their daily bodily work. It is through this prism of the organization of labour and mobility that we seek to capture the changes in senior care in CEE.

2. CEE at the Crossroads of Care Mobilities

Access to care in Europe is unevenly distributed. Not only Western countries, but increasingly CEE countries too are externalizing the costs of their demographic decline by relying on non-sustainable care mobilities. Mobile care workers are thus becoming the more or less formalized and regularized pillar of care systems across Europe. It is surprising how the increasing marketization of care mobility is met with widespread reluctance on the part of states, especially in CEE countries, which are particularly affected by the outmigration of care workers, to respond to this care crisis. Moreover, it is the absence of the state and political silence with regard to senior care needs that fuels the privatization of responsibility for senior care—for profit and not for profit. Even if the state supports the care sector as described in the example of Romania in this collection, with its rather "cosmetic" support for domestic services, this tends to lead merely to the formalization of such services rather than to their development towards accessible care systems with good working conditions (Hărăguș & Földes, 2026). What's more, some vulnerable groups of the older population, particularly older people who stayed behind when their family members outmigrated, fall out of the system (Dutchak et al., 2026a; Hărăguș & Földes, 2026). At the other end of the spectrum, however, we have the example of care systems like in the Netherlands, where strict regulation and generous funding only benefit the care receivers' side and do not really result in improved working conditions for the new trend of live-in care workers (Hernandez et al., 2026). Hrženjak's contribution on care recruitment from Bosnia and Herzegovina to Slovenian nursing homes shows yet another organizational role of the state as a key player in creating hierarchies via differentiated and unequal working conditions for migrant care workers (Hrženjak, 2026). Thus, even if the institutional care sector is better regulated than domestic care labour, it continues to be based on a hierarchy of rights, restricted mobility and segmented labour markets. The invisibilization of older people's needs is particularly serious in Ukraine, which has been supplying Europe with care workers for decades and where due to rapid demographic shifts, privatization reforms, labour migration and now refugee migration mainly by young women, the state is increasingly retreating from its responsibility and relying on international aid organizations, whose short term, project-based financial support can hardly meet the rapidly growing demand (Dutchak et al., 2026a).

3. Emerging Transnational Care Markets and Their Actors

New trans-European care markets are thus emerging, resulting from and creating an asymmetrical Europe. Migrant care work has become a commodity that is traded but also increasingly managed by transnational brokering agencies that are central to accessing work in better-off Western and Eastern European households; these agencies are also increasingly providing training (Fiebig-Spindler, 2026). As we demonstrate in this collection, the care sector has many faces but one common denominator: Almost all business and employment models (such as subcontracting structures, bogus self-employment, exceptions to labour law) are characterized by formalized precarity (Hrženjak, 2026; Katona & Gábriel, 2026; Palenga-Möllenbeck et al., 2026; Wojczewski et al., 2026). The risks are generally passed down to care

workers. Alongside international corporations, small-scale local entrepreneurs, often with backgrounds in sectors such as hospitality or construction, are entering the business of care for older adults. They extend their reach beyond national borders to recruit clients, reversing the usual flow of care mobilities by moving, this time, the people in need of care (Krause et al., 2026).

Brokerage agencies, work platforms and social media groups are also becoming key players in enabling and processing care work and care mobilities, in particular in the domestic care sector. With all the repercussions of unregulated platform work, they contribute in their own way to increasing job insecurity: In Hungary, for instance, due to the lack of purchasing power among care-receiving households, they are increasingly taking the place of formalized brokerage agencies, and contribute to the current opposite trend towards the informalization and deprofessionalization of the transnational domestic care sector (Katona & Gábriel, 2026); in Ukraine, Poland, and Germany, they partly share the digital infrastructure with brokerage agencies (Palenga-Möllenbeck et al., 2026).

At the same time, however, as demonstrated by the analysis of Poland as a "trans-European hub" for carers recruited not only from Poland but also from other EU and non-EU countries, care agencies and their representative organizations have gained significant influence in shaping the care market. As a "game changer" (Palenga-Möllenbeck & Fiebig-Spindler, 2025), they not only respond to existing regulations but also actively contribute to their development through lobbying, the establishment of industry standards, and everyday regulatory practices. Thus, this field is characterized by contradictory and hybrid dynamics that increasingly blur established categories and institutional boundaries. Agencies take on tasks traditionally associated with trade unions, trade unions broker jobs, workers become customers of agencies, and families become employers (Palenga-Möllenbeck et al., 2026).

The training and education of live-in care workers remain weakly regulated and fragmented (Deneva et al., 2026; Fiebig-Spindler, 2026; Katona & Gábriel, 2026; Wojczewski et al., 2026). CEE countries face challenges in establishing clear professional standards for care workers, which results in significant variation in workers' qualifications. In Austria, the majority of live-in care workers have care-related training certificates; however, formal qualifications are not legally required (Wojczewski et al., 2026). In Germany, there are no legally defined qualification requirements for live-in carers either, contributing to low levels of formal training (Fiebig-Spindler, 2026). In Hungary, the home-care market is seriously underregulated, and a growing number of short-term and online training programmes often provide certificates with no real value rather than recognized professional qualifications (Katona & Gábriel, 2026). Tacit knowledge and emotional labour are not only core elements of professionalism, but also hold together a fragmented institutional environment (Deneva et al., 2026; Dutchak et al., 2026b; Katona & Gábriel, 2026).

4. Towards Sustainable Paths to Decent Care and Working Conditions in the Care Sector

This thematic issue offers numerous points of reference, approaches, and examples of how transnational care can be organized in a sustainable and fair way. The EU's common political and economic structures definitely have potential and declare a common sense of good labour and desire to establish care standards, resulting in attempts to regulate the European care market.

Two of the articles examine how transnational justice in transnational care work can be derived from ethical approaches. Matiaško (2026) argues that the "right to care and support" as a new normative category is located at the intersection of political philosophy, human rights law, and constitutional jurisprudence. The recognition of the right to care makes visible precarious care arrangements, violations of care workers' rights, and regulatory shortcomings that might otherwise remain overlooked in social policy debates.

Aulenbacher et al. (2026) analyse how two forms of senior care provision in Austria and Germany, caring communities and the live-in sector, represent two types of shift, i.e., the marketization and communitization of care. Both models carry many risks of neoliberal externalization and privatization. The authors, however, advocate for new forms of care reorganization within caring communities that integrate transnational care migrants into local settings in a sustainable manner. Palenga-Möllenbeck et al. (2026) also highlight the key role of brokerage and independent mediation with strong elements of counselling and training in the live-in care sector, which would enable the formation of sustainable "working alliances" within flexible care and fair work.

In their analysis of a caring community in Hungary, Gábriel et al. (2026) discuss precisely this kind of local negotiation process and identify the potential and limitations of this type of governance. Local municipalities play an ambivalent role in relation to civil society organizations that foster community-based initiatives: while they provide space and infrastructure for local groups, they often respond more slowly than civil society organizations to emerging community needs.

New transnational solidarity networks, mainly on social media, represent new forms of labour struggles (Ezzeddine, 2026). The case studies on live-in work from the Czech Republic, Slovakia, Poland, Germany, Austria, and Ukraine show that industrial action is driven by numerous grassroots local initiatives and by NGOs and trade unions working together across national borders, and requires forms of industrial action that go beyond traditional trade union work. However, there are also many informal networks that now operate via interest groups in the digital sphere, providing a great deal of advice, information and networking opportunities (Palenga-Möllenbeck et al., 2026).

Acknowledgments

This research would not have been possible without the cooperation of our partners in the fieldwork, whom we would like to thank. We are indebted to Mariana Pires and the team of *Social Inclusion* for their professional support, as well as the anonymous reviewers, for their contributions, which significantly improved the quality of this thematic issue. Finally, we would like to express our gratitude to all the contributors to this collection.

Funding

Mainly funding from the CareOrg project (9C117, Volkswagen Foundation) was used for this research. Publication of this editorial in open access was made possible through the institutional membership agreement between Goethe University Frankfurt and Cogitatio Press.

Conflict of Interests

The authors declare no conflict of interest.

Data Availability

The data are confidential and largely concern vulnerable groups; therefore, only selected and anonymized datasets are available upon request.

LLMs Disclosure

Perplexity AI was used for formatting the references.

References

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage Publications.

Aulenbacher, B., Wegleitner, K., Hagedorn, J., & Emunds, B. (2026). In Times of the market and community shift: On live-in care and caring communities. *Social Inclusion*, *14*, Article 12295. https://doi.org/10.17645/si.12295

Deneva, N., Földes, I., Ursu, D., & Hărăguş, M. (2026). The winding road to professionalisation: Care work in Romanian nursing homes. *Social Inclusion*, *14*, Article 12326. https://doi.org/10.17645/si.12326

Dutchak, O., Fedyuk, O., & Oksiutovych, A. (2026b). Care dreams: How Ukrainian geriatric caregivers in Italy imagine their old age. *Social Inclusion*, *14*, Article 12324. https://doi.org/10.17645/si.12324

Dutchak, O., Fedyuk, O., & Oksiutovych, A. (2026a). Senior care in wartime Ukraine: A fragmented continuum of arrangements inside an "unpromising sector." *Social Inclusion*, *14*, Article 12060. https://doi.org/10.17645/si.12060

Ezzeddine, P. (2026). Bounded transport, mobility justice, and claims for recognition among live-in care workers. *Social Inclusion*, *14*, Article 12191. https://doi.org/10.17645/si.12191

Ezzeddine, P., & Uhde, Z. (2025). Borderscapes of care in Europe: The case of Czech live-in care workers in Germany. In N. Roman & B. Micheletto (Eds.), *Women, migration and the exchange of knowledge from the sixteenth to the twenty-first century* (pp. 399–418). Springer Nature. https://doi.org/10.1007/978-3-031-73982-8_14

Farris, S. R., & Marchetti, S. (2017). From the commodification to the corporatization of care: European perspectives and debates. *Social Politics*, *24*(2), 109–131.

Fiebig-Spindler, R. (2026). Selling care skills? The multiple meanings of training for Polish live-in care workers in Germany. *Social Inclusion*, *14*, Article 11909. https://doi.org/10.17645/si.11909

Fraser, N. (2022). *Cannibal capitalism: How our system is devouring democracy, care and the planet—and what we can do about it*. Verso.

Gábriel, D., Török, B., & Katona, N. (2026). Caring communities in urban Hungary: A civil society perspective. *Social Inclusion*, *14*, Article 12023. https://doi.org/10.17645/si.12023

Hărăguș, M., & Földes, I. (2026). Care under constraint: Unmet care needs among older adults in Romania. *Social Inclusion*, *14*, Article 12028. https://doi.org/10.17645/si.12028

Hernandez, S., Bartošová, K., & van Hooren, F. (2026). The limits of state control in regulating live-in care work in the Netherlands. *Social Inclusion*, *14*, Article 12375. https://doi.org/10.17645/si.12375

Hrženjak, M. (2026). Care extractivism beyond households: Migration and care for older people in the post-Yugoslav semi-periphery. *Social Inclusion*, *14*, Article 11975. https://doi.org/10.17645/si.11975

Katona, N., & Gábriel, D. (2026). Skill construction and challenges of professionalization in the Hungarian home care market. *Social Inclusion*, *14*, Article 12029. https://doi.org/10.17645/si.12029

Katona, N., & Melegh, A. (Eds.). (2020). *Towards a scarcity of care? Tensions and contradictions in transnational elderly care systems in Central and Eastern Europe*. Friedrich-Ebert-Stiftung.

Krause, K., Prieler, V., Horváth, H., Jelínek, M., Sapieha, M., Sekeráková Búriková, Z., Ezzeddine, P., & Schurian-Dąbrowska, L. (2026). Care outsourcing from Germany to Central and Eastern Europe. *Social Inclusion*, *14*, Article 12319. https://doi.org/10.17645/si.12319

Lutz, H. (2025). *The backstage of the care economy: Transnational perspectives on the commercialisation of care*. Pluto Press.

Matiaško, M. (2026). The right to care and support: Emerging normative landscape of social policy. *Social Inclusion*, *14*, Article 120562. https://doi.org/10.17645/si.12056

Melegh, A. (2026). Home care for sale: Marketisation and social change. *Social Inclusion*, *14*, Article 12737. https://doi.org/10.17645/si.12737

Palenga-Möllenbeck, E. (2024). Sozialtourismus in Deutschland? Wie reproduktive Arbeit unsichtbar wird. In M. Menz, D. Rellstab, & M. Stock (Eds.), *Körper und Emotionen in Bewegung: Migrationsgesellschaftliche Perspektiven auf Bildung, Politik und Familie* (pp. 145–169). Springer. https://doi.org/10.1007/978-3-658-42390-2_9

Palenga-Möllenbeck, E., & Fiebig-Spindler, R. (2025). Emerging home care markets in Central and Eastern Europe: Transformations of senior care, labour mobility, and housing in Poland and Germany. *Berliner Journal für Soziologie*, *35*, 549–564. https://doi.org/10.1007/s11609-025-00579-y

Palenga-Möllenbeck, E., Kyliushyk, I., & Fiebig-Spindler, R. (2026). The invisible hand of care: A typology of brokerage actors in migrant care labour. *Social Inclusion*, *14*, Article 11953. https://doi.org/10.17645/si.11953

Safuta, A. (2018). Fifty shades of white: Eastern Europeans' 'peripheral whiteness' in the context of domestic services provided by migrant women. *Tijdschrift Voor Genderstudies*, *21*(3), 217–231. https://doi.org/10.5117/TVGN2018.3.002.SAFU

Wojczewski, S., Ďurišová, S., Pleschberger, S., Ernst, A., Bagheri, R., Hoffmann, K., & Adler, V. (2026). Migrant live-in care workers in the global care chain: Results from an online survey. *Social Inclusion*, *14*, Article 11728. https://doi.org/10.17645/si.11728

About the Authors

Ewa Palenga-Möllenbeck (PhD) is a senior researcher in the Institute of Sociology and the Interdisciplinary Centre for Gender Studies, Goethe University Frankfurt. She is interested in the nexus of migration, work, care, and social inequalities, specializing in issues of ageing and transnational families, welfare/policy analysis, and intersectionality.

Dóra Gábriel is a sociologist and research fellow at the Centre for Economic and Regional Studies, ELTE, and a postdoctoral researcher at the Centre for Social Sciences, ELTE, Hungary. Her main research interests are care marketization, the communitization of care, and international retirement migration.

Olena Fedyuk holds a PhD in social anthropology from Central European University. Her research focuses on transnational labour migration, gendered work, labour sourcing agencies, and migrant workers' rights through action research. She is interested in feminist-informed research methodologies and has developed expertise in qualitative and visual methods, including documentary filmmaking.

Kristine Krause (PhD) is a professor of anthropology of health and care at the University of Amsterdam. Her research interests include transnational care, intimate outsourcing, citizenship, political subjectivities, and history.

Social Inclusion
2026 • Volume 14 • Article 11728
https://doi.org/10.17645/si.11728

cogitatio

ARTICLE

Open Access Journal

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

Silvia Wojczewski [1], Simona Ďurišová [2], Sabine Pleschberger [1], Anna Ernst [3], Rojin Bagheri [4], Kathryn Hoffmann [1], and Viktoria Adler [5]

[1] Department of Primary Care Medicine, Medical University of Vienna, Austria
[2] Initiative for Justice in Personal Care in Austria (IG24), Austria
[3] Department for International Development, University of Vienna, Austria
[4] University of Salzburg, Austria
[5] Department of Social and Preventive Medicine, Medical University of Vienna, Austria

Correspondence: Silvia Wojczewski (silvia.wojczewski@meduniwien.ac.at)

Submitted: 4 November 2025 **Accepted:** 6 April 2026 **Published:** 3 June 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

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.

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

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).

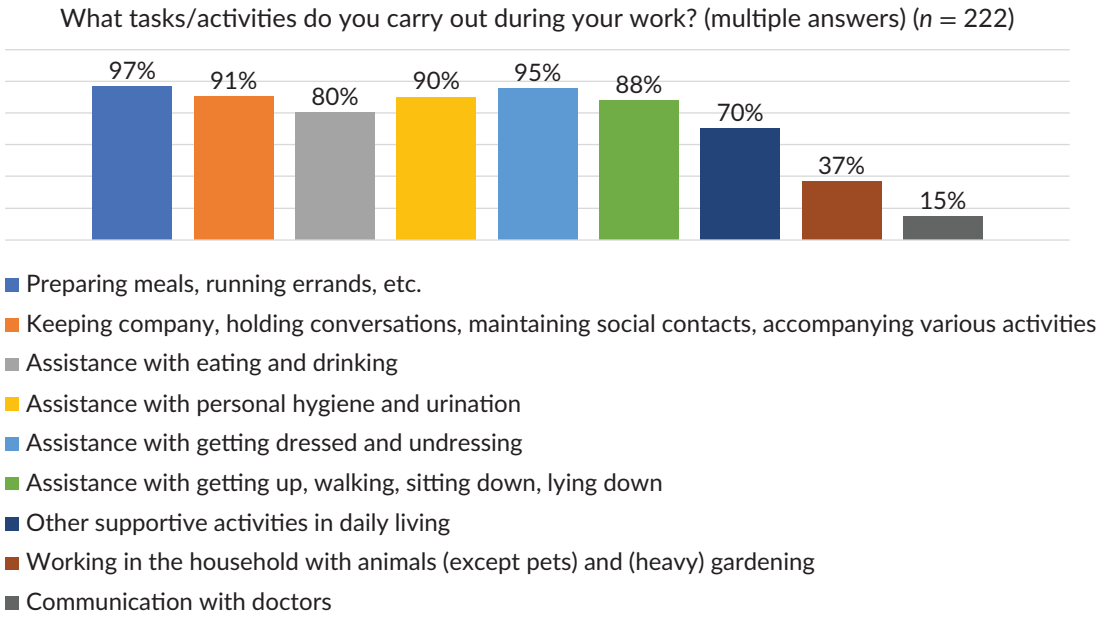


Figure 1. Work tasks.

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

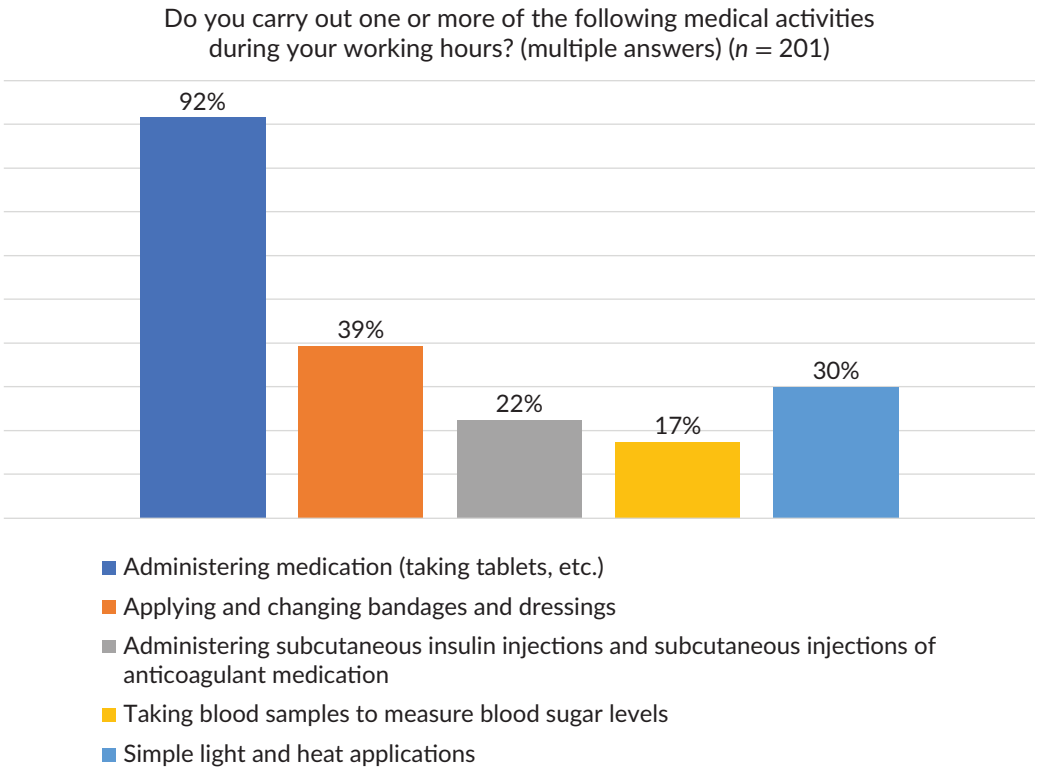


Figure 2. Medical tasks.

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).

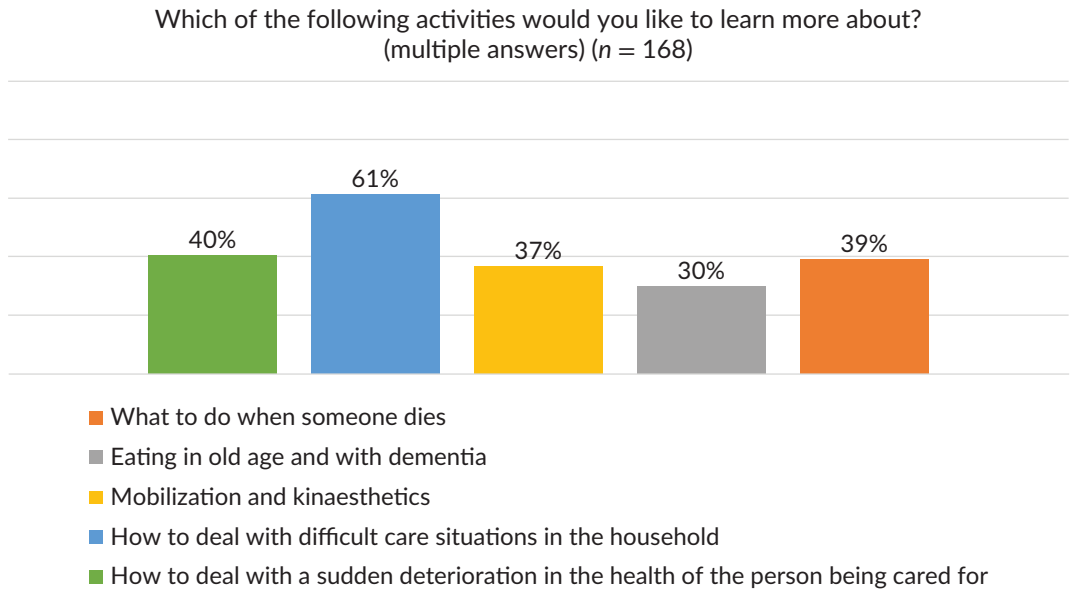


Figure 3. Further training needs.

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.

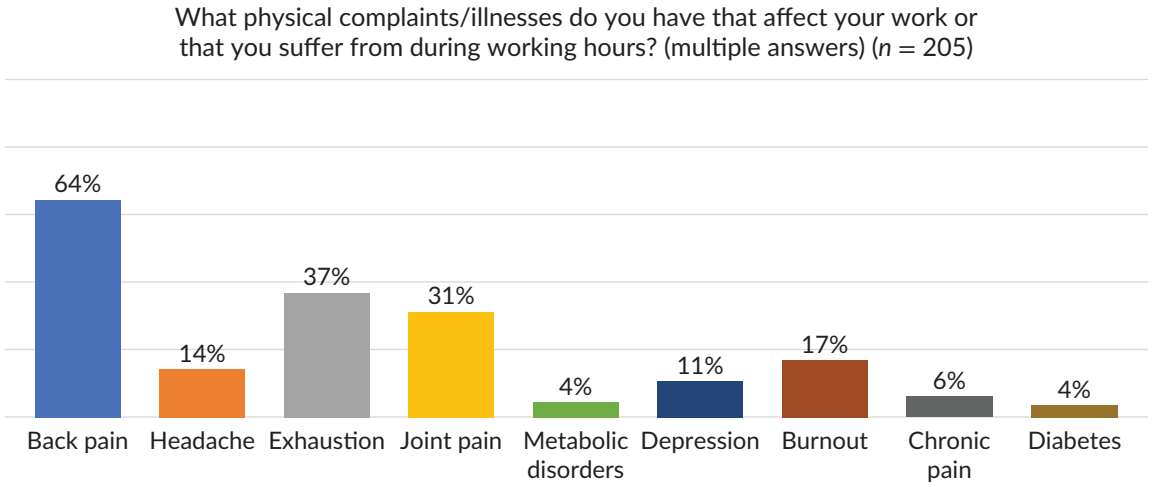


Figure 4. Health of live-in carers.

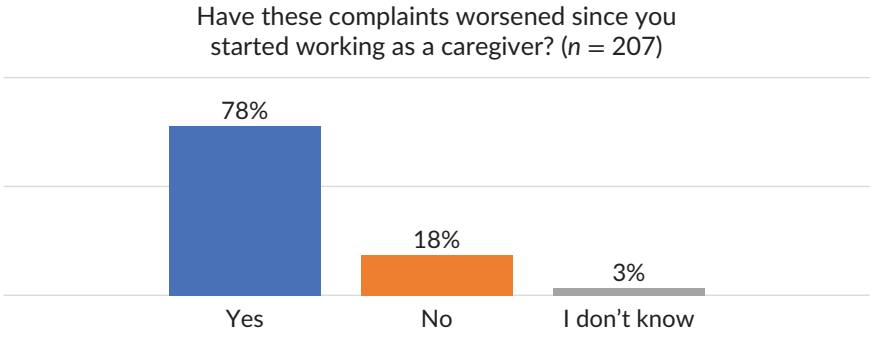


Figure 5. Deterioration of health.

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).

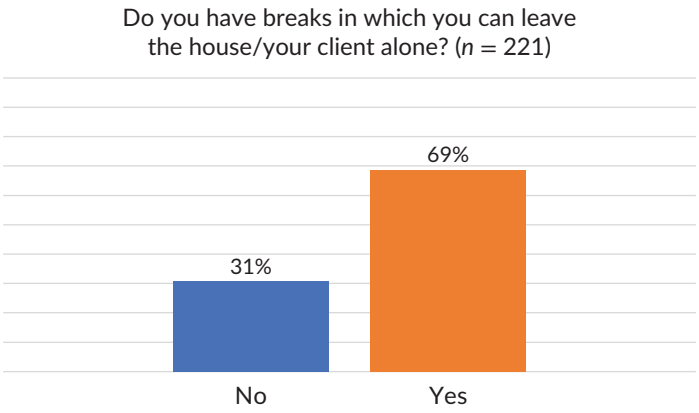


Figure 6. Work breaks.

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.

Acknowledgments

Thank you to all the MigraCare team members who were involved in designing and distributing the questionnaire. Special thanks go to Monika Vranceanu and Anna Durisova for their difficult design and translation work, and to Ingrid Sitter and Karin Sjögren Bauer for their consultation on the questionnaire design.

Funding

The MigraCare project was funded by the Ludwig Boltzmann Gesellschaft, the Open Innovation in Science Center, and Gesundheit Österreich GmbH as part of the Caring Communities for Future Lab.

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).

References

Aulenbacher, B., Leiblfinger, M., & Prieler, V. (2020). The promise of decent care and the problem of poor working conditions. *sozialpolitik*, *2020*(2), Article 2.5.

Aulenbacher, B., Leiblfinger, M., & Prieler, V. (2021). „Das Thema ist, die Menschen wollen zu Hause sein." Zum Nachdenken über Live-in-Care, Gütesiegel, staatliche Förderung und neue Betreuungsformen. In B. Aulenbacher, H. Lutz, & K. Schwiter (Eds.), *Gute Sorge ohne gute Arbeit? Live-in care in Deutschland, Österreich und der Schweiz* (pp. 212–235). Beltz Juventa.

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Aulenbacher, B., Lutz, H., & Schwiter, K. (Eds.). (2021). *Gute Sorge ohne gute Arbeit? Live-in-Care in Deutschland, Österreich und der Schweiz*. Beltz Juventa.

Aulenbacher, B., & Prieler, V. (2024). The 'good agency'? On the interplay of formalization and informality in the contested marketization of live-in care in Austria. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 79–94). Sage.

Ayalon, L. (2009). Family and family-like interactions in households with round-the-clock paid foreign carers in Israel. *Ageing and Society*, *29*(5), 671–686. https://doi.org/10.1017/S0144686X09008393

Ayalon, L. (2011). Examining satisfaction with live-in foreign home care in Israel from the perspectives of care recipients, their family members, and their foreign home care workers. *Aging & Mental Health*, *15*(3), 376–384. https://doi.org/10.1080/13607863.2010.519323

Ayalon, L. (2022). The global care network and its impact on sending and receiving countries: Current knowledge and future directions. *Ageing and Society*, *42*(10), 2244–2261. https://doi.org/10.1017/S0144686X21000027

Bachinger, A. (2015). 24-Stunden-Betreuung als Praxis: Identitätskonstruktionen, Arbeitsteilungen und Ungleichheiten—Eine Intersektionalitätsanalyse. *SWS-Rundschau*, *55*(4), 279–298.

Bauer, G., Rodrigues, R., & Leichsenring, K. (2018). *Working conditions in long-term care in Austria: The perspectives of care professionals* (Policy Brief No. 8). European Centre for Social Welfare Policy and Research. https://www.researchgate.net/publication/328381736_Working_Conditions_in_Long-term_Care_in_Austria_The_Perspective_of_Care_Professionals

Boris, E., & Parreñas, R. S. (2010). *Intimate labors: Cultures, technologies, and the politics of care*. Stanford University Press.

Bundeskanzleramt der Republik Österreich. (2026a). *Bundesrecht konsolidiert: Gesamte Rechtsvorschrift für Gesundheits- und Krankenpflegegesetz* (BGBl. I Nr. 108/1997). https://www.ris.bka.gv.at/geltendefassung.wxe?abfrage=bundesnormen&gesetzesnummer=10011026

Bundeskanzleramt der Republik Österreich. (2026b). *Bundesrecht konsolidiert: Gesamte Rechtsvorschrift für Hausbetreuungsgesetz* (BGBl. I Nr. 33/2007). https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20005362

BMSGPK. (2021). *Was dürfen Personenbetreuerinnen und Personenbetreuer tun? Information für Personenbetreuerinnen und Personenbetreuer in der 24-Stunden-Betreuung*. https://www.sozialministerium.gv.at/dam/jcr:1d6c92d1-2c4a-4688-87cf-f3c4c4221f45/210414_Merkblatt_PersonenbetreuerInnen_DE_pdfUA.pdf

Christensen, K., & Guldvik, I. (2016). *Migrant care workers: Searching for new horizons*. Routledge.

Cohen-Mansfield, J., & Golander, H. (2023). Bound in an imbalanced relationship: Family caregivers and migrant live-in care-workers of frail older persons in Israel. *Qualitative Health Research*, *33*(12), 1116–1130.

Cuban, S. (2013). *Deskilling migrant women in the global care industry*. Palgrave Macmillan.

Dowling, E. (2022). *The care crisis: What caused it and how can we end it?* Verso Books.

Ehrenreich, B., & Hochschild, A. R. (Eds.). (2003). *Global woman: Nannies, maids, and sex workers in the new economy*. Palgrave Macmillan.

Eurocarers. (2023). *Towards carer-friendly societies. Eurocarers country profiles: Austria*. https://eurocarers.org/country-profiles/austria

Eurofund. (2020). *Long-term care workforce: Employment and working conditions*. Publications Office of the European Union.

Famira-Mühlberger, U. (2017). *Die Bedeutung der 24-Stunden-Betreuung für die Altenbetreuung in Österreich*. WIFO. https://www.wifo.ac.at/wp-content/uploads/upload-7371/s_2017_24stundenbetreuung_60718_.pdf

Gerhards, S., von Kutzleben, M., & Schweda, M. (2022). Moralische Probleme der Versorgung von Menschen mit Demenz durch osteuropäische Live-in-Hilfen: Eine ethische Analyse der Erwartungen von Angehörigen in Onlineforen. *Ethik in der Medizin*, *34*(4), 573–590.

Geserick, C. (2021). *Die Personenbetreuung aus Sicht der Betreuten und Angehörigen* (ÖIF Forschungsbericht 41). Österreichisches Institut für Familienforschung (ÖIF), Universität Wien. https://doi.org/10.25365/phaidra.291

Green, O., & Ayalon, L. (2018). Violations of workers' rights and exposure to work-related abuse of live-in migrant and live-out local home care workers—A preliminary study: Implications for health policy and practice. *Israel Journal of Health Policy Research*, *7*, Article 32.

Hanrieder, T., & Janauschek, L. (2025). The 'ethical recruitment' of international nurses: Germany's liberal health worker extractivism. *Review of International Political Economy*, *32*(4), 1164–1188. https://doi.org/10.1080/09692290.2025.2450399

Ivanova, D. (2022). Articulating mobile gendered landscapes: Thinking with care cultures. *Health & Place*, *78*, Article 102727.

Lan, P.-C. (2022). Contested skills and constrained mobilities: Migrant carework skill regimes in Taiwan and Japan. *Comparative Migration Studies*, *10*, Article 37.

Lewicki, A., & Probst, U. (2026). Sex, care and the working body: Ambiguities of the gendered racialisation as 'Eastern European.' *Journal of Ethnic and Migration Studies*, *52*(1), 41–64. https://doi.org/10.1080/1369183X.2025.2462779

Lutz, H. (2011). *The new maids: Transnational women and the care economy*. Bloomsbury Publishing.

Lutz, H., & Palenga-Möllenbeck, E. (2015a). Care-Arbeit, Gender und Migration: Überlegungen zu einer Theorie der transnationalen Migration im Haushaltsarbeitssektor in Europa. In U. Meier-Gräwe (Ed.), *Die Arbeit des Alltags: Gesellschaftliche Organisation und Umverteilung* (pp. 181–199). Springer. https://doi.org/10.1007/978-3-658-07376-3_9

Lutz, H., & Palenga-Möllenbeck, E. (2015b). Global care chains. In A. Triandafyllidou (Ed.), *Routledge handbook of immigration and refugee studies* (pp. 139–144). Routledge.

Mairhuber, I., Schadauer, A., Neuhauser, J., & Matei, F. (2024). *Das Unsichtbare sichtbar machen: Datenerhebung zu Personenbetreuer_innen in österreichischen Privathaushalten*. IG24. https://ig24.at/wp-content/uploads/2025/11/Langversion_Ergebnisbericht_03.12.2024.pdf

Österle, A. (2012). Long-term care reform in Austria: Emergence and development of a new welfare state pillar. In C. Racni & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe: Investigating institutional change and social impacts* (pp. 159–177). Springer.

Palenga-Möllenbeck, E. (2014). *Pendelmigration aus Oberschlesien: Lebensgeschichten in einer transnationalen Region Europas*. transcript Verlag.

Parreñas, R. S. (2001). *Servants of globalization: Women, migration and domestic work*. Stanford University Press.

Prieler, V. (2021). 'The good live-in care worker': Subject formation and ethnicisation in Austrian live-in care. *Sociológia – Slovak Sociological Review*, *53*(5), 483–501.

Raghuram, P., & Kofman, E. (2004). Out of Asia: Skilling, re-skilling and deskilling of female migrants. *Women's Studies International Forum*, *27*(2), 95–100.

Ramsden, V. R., McKay, S., & Crowe, J. (2010). The pursuit of excellence: Engaging the community in participatory health research. *Global Health Promotion*, *17*(4), 32–42. https://doi.org/10.1177/1757975910383929

Schilliger, S., Schwiter, K., & Steiner, J. (2023). Care crises and care fixes under Covid-19: The example of transnational live-in care work. *Social & Cultural Geography*, *24*(3/4), 391–408. https://doi.org/10.1080/14649365.2022.2073608

Schwiter, K., Strauss, K., & England, K. (2018). At home with the boss: Migrant live-in caregivers, social reproduction and constrained agency in the UK, Canada, Austria and Switzerland. *Transactions of the Institute of British Geographers*, *43*(3), 462–476.

Spiliopoulos, G., & Cuban, S. (2025). Filipino migrant and returnee nurses resisting and adapting to the pressures of becoming "ideal migrants." *Journal of International Migration and Integration*, *26*(3), 1435–1460. https://doi.org/10.1007/s12134-024-01225-x

Trukeschitz, B., Österle, A., & Schneider, U. (2022). Austria's long-term care system: Challenges and policy responses. *Journal of Long-Term Care*, *2022*, 88–101. https://doi.org/10.31389/jltc.112

Wirtschaftskammer Österreich. (2025). *Anzahl der Berufszweigmitglieder nach Nationalität*. https://www.daheimbetreut.at/sites/default/files/downloads/FV127_BZ0200_2024_Nation.pdf

Wojczewski, S., Pentz, S., Blacklock, C., Hoffmann, K., Peersman, W., Nkomazana, O., & Kutalek, R. (2015). African female physicians and nurses in the global care chain: Qualitative explorations from five destination countries. *PLoS ONE*, *10*(6), Article e0129464. https://doi.org/10.1371/journal.pone.0129464

About the Authors



Silvia Wojczewski is a medical anthropologist. Her research focus is on transnational care migration, informal care networks, and crisis management. Silvia works with participatory research methods. She was PI of the MigraCare project on including live-in care workers in care networks in Austria. She uses a feminist intersectional lense.



Simona Ďurišová is a co-founder of the Initiative for Justice in Personal Care in Austria (IG24), an association supporting migrant live-in carers through counselling and advocacy for improved working conditions. In her master's thesis, she examined the labour and social disadvantages faced by live-in carers and the role of placement agencies.



Sabine Pleschberger (PhD, RN, MPH), in an endowed professor for nursing science at the Center for Public Health, Medical University of Vienna. She has an interdisciplinary background in nursing, sociology, and public health. Her fields of interest cover formal and informal caregivers in the area of care for older people until the end of life.



Anna Ernst holds a BA in cultural management from the University of Passau, where she spent a semester abroad at Akita University in Japan, and an MA in international development from the University of Vienna. Her research focuses on migration, irregular migration, care work, and social inequality. She is currently a project manager at Zubaka GmbH in Frankfurt am Main.

Rojin Bagheri is a research assistant at the Department of Sociology at the University of Salzburg. Her research focuses on social inequalities, particularly those related to gender. In her doctoral research, she aims to combine feminist and ecological perspectives in order to critically examine society's relationship with nature.



Kathryn Hoffmann is a medical specialist in general practice and family medicine, and a public health expert. She holds a full professorship in primary care medicine and heads the department of the same name at the Center for Public Health at the Medical University of Vienna in Austria.



Viktoria Adler is an anthropologist. She specialises in gender, migration, and medical anthropology. Recently, she has focused her research on participatory approaches to include people in vulnerable situations in local crisis management, and on questions of social cohesion and care work in times of crisis.

Social Inclusion
2026 • Volume 14 • Article 11909
https://doi.org/10.17645/si.11909

cogitatio

ARTICLE

Open Access Journal

Selling Care Skills? The Multiple Meanings of Training for Polish Live-In Care Workers in Germany

Roxana Fiebig-Spindler

Institute of Sociology, Goethe University Frankfurt, Germany

Correspondence: Roxana Fiebig-Spindler (fiebig-spindler@soz.uni-frankfurt.de)

Submitted: 5 January 2026 **Accepted:** 30 April 2026 **Published:** 25 May 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Migrant care workers from Central and Eastern Europe are essential to Germany's senior care system, yet their work remains undervalued and poorly regulated. While brokerage agencies often frame live-in care as a "win-win solution," it is characterized by challenging physical and emotional labor, precarious working conditions, low pay, legal ambiguity, and long working hours. Over the past 15 years, the sector has shifted from informal arrangements to a formalized market increasingly dominated by transnational brokerage agencies. These agencies not only recruit and place workers in households, but also offer services such as consulting, lobbying, and increasingly education through specialized training programs for live-ins, presenting themselves as drivers of professionalization and formalization. However, there are no legally defined qualifications for live-in carers. To appeal to clients, agencies depict Polish caregivers both as "naturally skilled" due to gendered, ethnicized, and age-related attributes and as "trained and experienced" through internal courses. This article explores the multiple meanings of training by examining its role from the perspective of both agencies and live-in care workers, based on narrative interviews and fieldwork in Poland and Germany and by adopting an intersectional lens. The article argues that although training has the potential to improve working conditions and care quality, it remains limited by structural inequalities and a lack of regulation. Without broader legal reforms, there is a risk that training will continue to serve more as a marketing strategy for agencies than as a tool for the genuine, fair, and sustainable formalization of the live-in care sector.

Keywords

care brokerage; labor mobility; live-in; marketization; migrant care work; training for care workers; transnational senior care

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

In Germany, as in many Western European countries, migrant care workers from Central and Eastern Europe, particularly from Poland, play a crucial role in meeting the increasing care demands of an aging population. Even two decades after the EU's eastward enlargement, a geopolitical division persists, with Central and Eastern European countries primarily serving as sending states for care workers, while wealthier Western nations function as receiving countries (Aulenbacher et al., 2024, p. 4). This pattern reflects economic inequalities, demographic shifts, and policy frameworks that shape a transnational care market characterized by feminization and precarity (Theobald, 2018). The live-in care model, where migrant caregivers reside in private households, has become an important pillar of the German care system, with an estimated 500,000 caregivers, most of them from Poland (Lutz & Benazha, 2020, p. 7). The EU promotes an adult-worker model, encouraging women to participate in full-time employment (Lewis & Giullari, 2005). However, Germany's familialistic care regime continues to assign primary responsibility for care work to women, creating a "double burden" for them (Palenga-Möllenbeck & Fiebig-Spindler, 2025, p. 559). Transnational live-in care is often framed as a "win-win solution" (Aulenbacher et al., 2021, p. 119) to this dilemma: Families access affordable care that aligns with cultural preferences for aging in place, while migrant care workers, mostly Polish women in their 50s or older, are attracted by financial incentives such as the 1:3 income gap between Germany and Poland (Palenga-Möllenbeck, 2024). This enables (German) women to buy themselves out of reproductive labor to engage in paid employment, resulting in an ethnicized redistribution of care work to women from poorer countries (Hess, 2002, p. 109), as well as the defamilialization and commodification of care. However, live-in care workers face structural inequalities, such as low wages ranging from €1,500 to €2,200 net per month (regardless of whether they are employed irregularly or through an agency), long working hours, emotional and physical strain, the requirement that they be available around the clock, and often no or limited protection under labor law. Clients who wish to use a brokerage agency to employ live-in care workers have to pay around €3,500 per month in total, which is why the black market is still attractive. The live-in care model is characterized by a lack of regulation and control mechanisms, resulting in a female-dominated labor market segment with precarious working conditions (Theobald, 2018). The German state, as Lutz and Palenga-Möllenbeck argue, plays a complicit role in this system, which reflects neo-colonial structures of care work organized along gendered and racialized lines (Lutz & Palenga-Möllenbeck, 2010). This devaluation of both care and migrant labor contributes to a general reluctance to invest in or pay adequately for live-in care.

Furthermore, national migration policies shape the integration of migrant workers into labor markets (Lutz & Benazha, 2020). In the case of Germany and Poland, both EU member states, freedom of movement applies. Combined with Germany's cash-for-care system, the state effectively acts as a knowing accomplice, tolerating undocumented and informal care work in private households to prevent the collapse of an inadequate care system and avoid public criticism over its failures (Lutz & Palenga-Möllenbeck, 2011).

Despite their central role in senior care, Polish live-in caregivers lack formal training and professional recognition, as there are no legally defined qualification standards. Brokerage agencies present them as experienced, dedicated, and culturally proximate quasi-family members (Prieler, 2021, p. 1), reinforcing the notion that what they need and possess are "natural" caregiving skills. Thus, the ideal caregiver personality type is coded as feminine and associated with specific cultural/ethnic backgrounds (Nyssen, 2024, p. 55) and a certain age. Therefore, training programs must be examined not just as skill-building measures, but through

an intersectional lens as sites where economic interests, social hierarchies, and normative expectations surrounding care work intersect along gendered and ethnicized lines.

At the same time, care recipients and their families increasingly expect certain qualifications, particularly in language proficiency and caregiving skills. In response, agencies have introduced training programs aimed at enhancing the marketability of care workers and legitimizing their services (which, in contrast to those available on the black market, are often more expensive). However, live-in care work covers a wide range of activities that are not legally regulated, including housekeeping, cooking, personal care, and companionship, all of which require person-centered care (Grenz & von Kutzleben, 2024, p. 7), a holistic proximity to the care recipient, and "emotional labor" (Hochschild, 1985). This individual approach to care relies heavily on implicit knowledge, "informal learning" (Latham et al., 2024), and so-called soft skills, including physical and psychological resilience and the ability to build emotional relationships with the care recipients. Thus, as this article will show, the standardization and formalization of live-in care, and thus training for live-in carers, remain highly challenging.

2. Data and Methodology

This article is based on data and findings from the international research project CareOrg – Researching the Transnational Organization of Senior Care, Labor and Mobility in Central and Eastern Europe, funded by the Volkswagen Foundation from 2023 to 2027. The project examines the marketization and transnational organization of senior care in Central and Eastern Europe. This study specifically draws on data from the Polish-German sub-project. The primary findings stem from semi-structured interviews conducted in Germany and Poland between 2020 and 2025 with two owners of German brokerage agencies, four owners of Polish agencies, 10 employees of Polish agencies, two representatives of trade unions, two representatives of a counselling center, and three representatives of employers' associations. Additionally, a focus group interview with six Polish care workers and 12 individual interviews with Polish care workers were conducted. In addition, participatory observations were conducted during training sessions for care workers and recruiters, as well as an online first-aid course. A content analysis of agency-provided learning materials, including e-learning courses, complemented the data. The analysis was guided by questions on how different actors assess training, which skills and qualities they emphasize, and how references to ethnicity, gender, and age shape these perspectives. All interviews were conducted in the participants' native language, transcribed, and analyzed using MAXQDA following a grounded theory approach (Glaser & Strauss, 2017). This approach informed not only data collection and coding but also the inductive development of categories through constant comparison across interviews, observations, and materials. The analysis is structured around emerging themes, tensions, and contradictions, foregrounding the situated perspectives of different actors.

3. Formal Training in the Live-In Care Sector

For the purposes of this article, I define the training offered by brokerage agencies as formal due to the absence of a regulated system of standardized qualifications with officially recognized credentials for live-in care workers: It is voluntary, free of charge, based on internal standards and curricula, and typically results in certification for care workers. In contrast, informal training refers to non-standardized, individualized instruction or learning that takes place directly "on the job," through experience and improvisation in everyday care work.

Drawing on Hayes et al. (2019), I conceptualize professionalization in long-term care as the improvement of care workers' qualifications through regular training, alongside enhanced pay and working conditions. In line with Kispeter and Hussein (2026), I also consider the quality of care—particularly person-centered approaches—and care workers' autonomy, defined as their discretion to make confident decisions independently, as additional dimensions of professionalization. Furthermore, professionalization in the context of live-in care also means the professionalization of the services offered by intermediary agencies. The placement of Polish care workers in German households has shifted from an informal transnational care chain to a formalized and complex value chain (Palenga-Möllenbeck, 2024, pp. 23–24). Previously informally arranged through direct agreements or migrant networks, live-in care work has now become increasingly formalized and professionalized in response to the growing marketization of care work across Europe (Farris & Marchetti, 2017) and brokered by intermediary agencies (Aulenbacher et al., 2024, p. 25). These agencies play a key role in self-regulating, lobbying, and promoting the largely unregulated live-in care sector (Aulenbacher et al., 2021, 2024; Leiber et al., 2021; Palenga-Möllenbeck, 2024). Beyond recruitment and placement, they offer management, professional, and administrative support, marketing, lobbying, and increasingly a wide spectrum of training formats, including webinars, on-site courses, online learning platforms, informational materials via Facebook or agency websites, and consulting hotlines. Thematically, training spans illnesses common in old age (e.g., dementia, Alzheimer's, Parkinson's, diabetes), hygiene and care techniques (e.g., caring for bedridden patients, changing adult diapers), the use of assistive devices (e.g., operating a lift), first aid, language skills, and psychological topics (e.g., depression or dementia). The duration of training courses also varies greatly. Online courses on specific topics usually last between one and two hours, while on-site training courses can last from two hours to several days. One employers' association recommends a qualification that comprises a total of 440 hours (including 80 hours of online learning on domestic care and 320 hours of practical work).

Digital formats are attractive for live-ins, as this enables workers to access materials across borders and at flexible times, and agencies, because they are cost-efficient, enable participation tracking, and reach a wide audience. However, they also create barriers. Most live-in caregivers are over 50, and some well into their 70s, with varying degrees of digital literacy. According to one agency's head of training, around 20% of caregivers cannot complete online training at all, 30% require significant support, and only 50% manage independently. This illustrates how digital learning presupposes certain abilities such as reading comprehension, concentration, and digital competence, as well as reliable access to technology, thereby excluding some groups of caregivers.

Some agencies also provide expert hotlines staffed by nurses or psychologists, offering personalized advice. While highly valued in light of the holistic care approach expected from live-in workers, this individualized support by specialized staff is costly for agencies and therefore often substituted by internal staff such as recruiters or project managers who hold additional qualifications (e.g., nutrition, psychology, physiotherapy).

4. Field Examples: Experiences From an Online Course and an On-Site Workshop

The online first aid course I attended was free of charge and open to the public, offered by a large Polish agency. Participation required registration with personal contact details via the agency's website, after which I received a link to the online session. Two days prior to the course, I received a reminder text message in Polish, asking me to indicate my motivation for attending. An additional reminder email, including the webinar link, was sent

one hour before the course. The session took place at 7 p.m. and lasted nearly two hours. Unfortunately, the number of participants in the online course was undisclosed, though there was lively participation in the chat.

The course appeared to be highly professional in its organization and delivery. Two young nurses, who served as trainers, presented practical knowledge, discussed relevant legal regulations concerning first aid, answered questions, and illustrated their input with examples from real-life situations in which live-in caregivers had been required to administer first aid. However, online formats face considerable limitations in relation to practical skills, since there is no possibility of hands-on demonstration and repetition. Thus, participants were encouraged to reinforce the acquired knowledge by taking an on-site first aid course to learn techniques such as cardiopulmonary resuscitation (CPR) with professional guidance.

The online course functioned not only as a skill-building measure, but also as a recruitment and marketing tool. Throughout the presentation, participants were repeatedly encouraged to consult the agency's job offers or to rate the company positively on Google and Facebook. Immediately after the course, I received an email—this time in German, whereas all previous communication had been in Polish—with a link to download a training certificate. The following day, another email provided access to the course recording on YouTube. Since attending, I have regularly received further emails with job offers from the agency, underlining that the online course serves not only as a training opportunity but also as a key recruitment strategy for care workers.

I also attended an on-site training session on maintaining a healthy back at work, organized by another large Polish agency and delivered by a staff member who was also a trained physiotherapist. The session took place at the agency's head office and was attended by around 15 care workers, most of them in their 50s and 60s, with two participants in their 70s. The agency created a welcoming atmosphere by providing hot and cold drinks as well as snacks. After the training, the workshop organizer told me that this was important to make participants feel comfortable and valued.

The physiotherapist demonstrated techniques for performing physically demanding tasks, such as lifting people in wheelchairs or transferring them to a bed, in ways that minimize physical strain. He also introduced muscle relaxation exercises and presented supportive tools, including small self-massage devices that participants could try out during the session. Ample time was set aside for questions and discussion, which proved particularly important given the participants' strong need to exchange experiences. Since most live-in caregivers work in isolation in Germany and rarely have opportunities to meet colleagues, the training session also served as a valuable space for social interaction and peer support. Outside such settings, peer-to-peer exchange is typically limited to travel time between Poland and Germany, as care workers often commute together via door-to-door transport services, such as agency-organized minibuses, or to online forums, including Facebook groups. At the end of the session, participants received a certificate along with a small goodie bag containing the agency's marketing materials.

5. Selling Care: How Agencies Invest in Training as Strategy

The field examples described above highlight the ambivalent role of training provided by agencies in the live-in care sector. On the one hand, agencies provide structured learning opportunities, offer certification, and facilitate cross-border knowledge transfer. On the other hand, training also serves as a recruitment and

marketing tool and key instrument through which agencies manage client expectations and position themselves in a highly competitive market. This section explores these tensions in greater detail.

Trained staff enhance agencies' competitiveness in the care market by meeting German clients' high expectations regarding caregivers' skills and knowledge. As the head of recruitment at a large Polish agency explained, agencies must justify higher fees to clients and distinguish themselves not only from competitors but also from the still-prevalent informal (black) market:

> Ladies who used to work in the black market don't know how the market has changed over the years, how it all works. Our main task is to make them aware of this and to sell them this training product, because this way we have an easier way later on to sell…let's say the carer, to offer her as the attractive option, more attractive than the others who don't have this training.

In this context, training becomes a tradable resource within the transnational value chains shaped by brokerage agencies (Palenga-Möllenbeck, 2024). Higher qualifications and enhanced knowledge not only improve the quality of care but also increase satisfaction among both clients and caregivers. This, in turn, lowers agency costs by decreasing the frequency of unplanned caregiver changes—events that often generate additional administrative work and transportation expenses. Moreover, given intense competition, agencies depend heavily on positive recommendations from both clients and caregivers.

Nevertheless, many agencies restrict access to free training to specific groups. For example, one agency provides an online language course to all prospective caregivers, but full access to its learning platform is reserved for those already formally contracted. In this way, introductory courses function as recruitment tools designed to attract new workers, while more comprehensive training serves to secure loyalty among those already employed.

Some agencies are implementing training programs in anticipation of future regulations mandating basic qualifications for live-in caregivers, even if the immediate return on investment is limited. As one German agency owner put it:

> It's a mixture of—you believe in it, you believe it improves quality, you're preparing for the future, and you hope it will become binding at some point.

Still, all interview partners emphasized that investing in training is financially risky, as caregivers can readily find work without formal qualifications and are often not interested in training. As a representative of an employers' organization put it:

> What motivation does a 63-year-old caregiver from Romania have to pay several hundred euros for a course when she could still find a job without it?

One agency reported that although external caregivers can purchase access to their online courses, there is limited demand. Another agency owner recounted how she sold her jewelry when she first started her business to fund German lessons for caregivers, but many of the trainees left the agency soon after completing the course to work for others or informally. Since there are now many free online German courses available, the

agency owner stopped offering her own courses. This underscores the difficulty of retaining workers, making investment in training risky for agencies. Consequently, only large agencies with many employees, clients, and caregivers are currently in a position to afford and sustain training programs. Thus, many stakeholders advocate for the introduction of a standardized employment model with minimum qualification requirements in order to curb the black market, improve working conditions, and enhance the quality of care. They argue that such measures should be publicly funded to ensure fair caregiver compensation and avoid placing additional financial burdens on families, which could lead to a shift back to the black market.

All the agencies we interviewed emphasized the shortage of staff as one of the sector's greatest challenges, as many caregivers themselves are aging. Offering training, counselling, and support helps agencies position themselves as attractive employers, fostering satisfaction and loyalty among care workers while reducing turnover. At the same time, the economic and social conditions in Poland are improving, making it easier for younger, better-educated individuals—especially women—to find work domestically or in more appealing sectors abroad. As a result, agencies are increasingly recruiting from less affluent Eastern European countries such as Romania, Ukraine, and Bulgaria to meet rising demand. This trend reflects and reinforces racialized assumptions and global inequalities, as one recruitment manager from a Polish agency openly admitted:

> These ladies are more hardworking and committed. Our carers have been going to Germany for years. Their expectations have increased—they want to earn more while doing less. Women from the eastern border, like Romania or Ukraine, are in a different situation. They know they have to work hard to earn a good wage. It's just easier with them.

However, the recruitment manager acknowledged that many of these women lack German language skills, making the development of training and language courses increasingly important. In this way, agencies seek to meet client expectations without improving working conditions or raising wages—ultimately perpetuating global care injustices. The following section examines in more detail how agencies manage client expectations by drawing on and reproducing narratives that frame care as a culturally inherited and "natural" ability of women, particularly those from Central and Eastern Europe.

6. Between Naturalized and Professionalized Notions of Care: How Agencies Manage Client Expectations

Live-in care is predominantly performed by women, reflecting gendered norms that frame care and domestic labor as inherently "female" (Lutz & Benazha, 2020). Such work is often perceived as natural and unskilled, contributing to its ongoing devaluation and low pay (Bolton, 2009). Feminist scholars have long challenged this narrative, emphasizing the essential role of care work for both human sustenance and societal reproduction, inside and outside the formal labor market (Ivancheva & Keating, 2020).

In live-in care, these conceptions intersect with ethnicity. Agencies frequently use national origin—particularly from Central and Eastern Europe—as a marketing tool, portraying caregiving as a culturally inherited skill. For instance, Polish caregivers are often depicted as especially suited to care due to presumed multigenerational family traditions, despite evidence that such family structures are no longer predominant in Poland (Bartova et al., 2023).

Ethnicity, gender, and age shape the construction of the "ideal" live-in caregiver (Aulenbacher et al., 2021; Prieler, 2021, p. 487). Women, especially women from Eastern Europe, are frequently assumed to possess an innate motivation and ability to care, alongside availability around the clock and resilience (Pfeil et al., 2020; Weicht, 2011). However, a former Polish agency owner criticized the cultural essentialization of Polish women and stressed the need for psychosocial skills:

> It seems to them [the German clients and German agencies] that because we still live in multi-generational families and homes in Poland, we take care of our seniors at home, although it's not quite like that either. They think this is enough. Well, unfortunately, it is not enough, because to be able to work with a sick person or with an older person, you need to have some psychosocial predisposition.…It is also necessary to simply have a way with these people.

The feminization and ethnicization of care workers intersect with age-related discourses. Clients often favor older women, associating age with life experience, maternal traits, and a strong sense of duty (Krawietz, 2014). Yet beyond a certain age—typically 70—caregivers may be seen as physically unfit for the job.

Live-in workers are expected to fulfill multiple, often contradictory roles: service providers, professional caregivers, moral actors, and quasi-family members (Gerhards et al., 2022). However, these expectations are rarely met in practice. Furthermore, agencies valorize motives such as a calling to help others, while financial necessity is viewed negatively (Chau, 2019; Prieler, 2021, p. 489), as this quote from a Polish agency owner shows:

> Germans expect a professional, trained caregiver to come to their home and provide care services. She doesn't smoke, has a driver's license, and is between 40 and 60 years old. Believe me, I might still find someone aged 50–60, but a non-smoking, empathetic caregiver aged 40–50? No. Most of these women are struggling financially in Poland for various reasons.…They learned German somewhere, at school, but they are not truly suited as a caregiver.

According to agencies, clients value person-centered care, emotional engagement, and language skills (Grenz & von Kutzleben, 2024). However, clients are not willing to pay more for the latter, forcing agencies to balance the expectations of clients and caregivers, as this example from a Polish agency manager who had lived in Austria for many years shows:

> The lady…says: "Please find me a carer, I want her to talk like you." "But I'm at level C1." "Well, I can communicate with you," she says. "But I'm at level C1! I can go to university in your country and study normally, as a student.…If that's the language level you want, you will have to pay x euros extra." And she says, "No, that's too expensive."

To prevent potential conflicts about unmet expectations, some agencies offer sample recordings of carers speaking German. Most agencies also work with bilingual recruiters and managers and offer free online language courses for job applicants without language skills. A training manager at a major Polish agency described this approach as "creating" a care worker. Another reported strategy of agencies to improve the employability of their care workers was to exaggerate their informal care experience, e.g., suggesting that visiting a bedridden aunt equals "three months of experience." Training certificates and references—collected

from families to validate caregivers' experience and competencies—are becoming increasingly important. Ultimately, however, compatibility is often valued more than formal qualifications, as one agency owner put it:

> They have to match. It's not even about skills, but to a client who likes to shout and dominate, you don't send a carer with the same traits…you have to send one who is polite, compliant. And vice versa…and that way everybody is happy.

In conclusion, brokerage agencies align their qualification criteria with client expectations while struggling to meet high demands within the constraints of low wages and a limited workforce. Following a neo-colonial and neo-liberal logic, they employ various strategies, including training programs and exaggerated portrayals of experience and skills, while at the same time focusing on interpersonal compatibility and gendered and ethnicized marketing to "sell" caregivers to clients. Crucially, while skills such as empathy, patience, and communication are in many professions taught, assessed, and formalized through training, in live-in care they are frequently framed as personal traits rooted in gender, culture, or upbringing. This framing shifts them from the realm of acquired competencies to that of presumed "natural" dispositions, particularly when associated with femininity or specific national backgrounds. As a result, these skills are less likely to be recognized as qualifications that require investment, remuneration, and formal validation. By emphasizing soft skills in this essentialized way, agencies present training as optional—while using it to signal their professionalism without altering structural conditions such as contracts, wages, or working hours.

7. Caring as Calling? Polish Live-Ins Navigating Skills, Values, and Expectations

While the previous section has shown how agencies use training and frame skills to meet client expectations and to position themselves in a competitive market, this section shifts the focus to caregivers' perspectives, highlighting the fundamental tension Polish live-in care workers experience between person-centered care, framed as a quasi-familial "calling" grounded in supposedly innate qualities and values, and processes of professionalization.

When asked about key qualifications, carers emphasize soft skills, especially empathy and patience, as essential for working with older or ill individuals, such as those with dementia. This focus reinforces dominant narratives that portray caregiving as an innate ability. Yet their accounts also reveal an ambivalence: While some describe the job as "just like at home," likening it to household chores and reproducing the image of unskilled reproductive labor, others stress the hardships of transnational care work—poor conditions, isolation, long absences from family, and the "high physical, mental and emotional costs of live-in care" (Prieler, 2021, p. 489). In light of these challenges, psychological resilience is often seen as the most important skill.

Therefore, caregivers often cope with the emotional demands of their work by familiarizing the care setting, calling the care recipients "grandma" or "grandpa," and adopting Christian philosophies like "you reap what you sow," as one carer expressed it:

> When I do something, it's like I'm doing it at home….It's like taking care of my own mother….I can't do it any other way. Maybe that's why it comes back to me in some way.

Care workers also take up the discourse of the "right" motivation for working as a live-in carer (Prieler, 2021, p. 489), often citing strong family bonds and Christian values. This reinforces the enduring Polish myth of the "Matka Polka" (Polish Mother), which is historically rooted in the times of the Partitions of Poland and portrays women as self-sacrificing caregivers. It is entangled in the relations of the social hierarchy of power, disciplining women into accepting caregiving and motherhood as the basis of women's identity and the most important determinant of their social roles in the national community (Hryciuk & Korolczuk, 2012, pp. 11–12).

Older women in Poland particularly have internalized these gendered expectations that also shape how Polish carers perceive German attitudes toward (senior) care, which they see as selfish and cold. That way, care workers reaffirm their self-worth within the asymmetric power dynamics they face, as this quote from a Polish care worker shows:

> Well, unfortunately, this is the German mentality, isn't it, that children don't feel obliged to take care of their parents and that parents…don't want to bother them….For us this is sad, we are taught differently in Poland….They cannot imagine how you can devote your life…to taking care of your own mother at home.

Carers are expected to provide holistic, individualized care and to conform to the daily rhythms and preferences of care recipients. Nonetheless, this does not mean they lack agency. Many actively shape their working conditions by finding creative solutions to manage their workload, as illustrated in this anecdote from a care worker:

> I recently worked with an older couple—a man with Parkinson's and a woman with dementia. When I arrived, I learned I was expected to shave the man. I had never done that before and didn't feel comfortable with it. So, I turned to his wife and said, "You know how he likes it." For the next two months, she shaved him herself, bringing his razor every morning.

While care workers stress the importance of innate "soft skills," a 2023 online survey from the Austrian MigraCare project found that 76% of the 225 migrant live-in carers surveyed wanted more training in specific areas (Wojczewski et al., 2023). The most requested topics included managing difficult caregiving relationships, understanding legal rights and responsibilities, and handling aggression or sexual harassment. Our research confirms that the caregivers who participated in the training sessions found them very useful and would like to continue receiving training in the future. These findings highlight the need to provide care workers with better access to education and information. However, formal training occupies an ambivalent position for live-in care workers, as will be discussed in the following section.

8. Opportunities and Limitations of (In)Formal Training From The Care Workers' Perspective

Many caregivers perceive limited benefits regarding formal training—particularly when additional qualifications do not translate into higher pay (Sobiesiak-Penszko, 2015). Given the already high costs of live-in care for families (such care is only affordable for upper-middle-class households) and the limited state subsidies available (Palenga-Möllenbeck & Fiebig-Spindler, 2025, p. 8), agencies reported that many clients are unwilling or unable to pay more for better-qualified staff. As a result, incentives to invest time and effort

in training remain low. However, our research underscores the central role of language skills in live-in care. Beyond improving salaries, such skills shape relationships with care recipients and families, enable the negotiation of working conditions, and are essential in emergencies. When these skills are absent, there is an increase in vulnerability, as one caregiver's story illustrates: For five years, she endured exploitative conditions—caring for a woman with dementia, cooking for extended family and neighbors, and performing tasks she wasn't trained for, such as speech therapy and physical activation—without the language confidence to set boundaries. Our research confirms that care workers tend to compensate for limited skills by taking on extra duties. However, others mitigate gaps through strategies like using translation apps or relying on bilingual agency staff. In addition, most live-in caregivers are retired or approaching retirement age (Rösler et al., 2023), and have already extensive care experience and little interest in career advancement. As the existing training is not standardized, it does not enable care workers to progress in their career anyway, for example by moving into a different sector, and this also makes it unattractive for younger live-ins. Practical barriers—including age, educational background, and the need to use scarce free time for training—further limit participation.

At the same time, live-in care workers acknowledge that training in areas such as care techniques, managing age-related illnesses, understanding rights and responsibilities, and language acquisition can provide important benefits. Specialist knowledge, e.g., about dementia, can improve the quality of personalized care (Damant et al., 2023; Ettelt et al., 2020), and so can training that aims to improve care workers' emotional and interpersonal skills (Hayajneh & Shehadeh, 2014; Manthorpe et al., 2017). Training can increase their confidence, improve their communication and negotiation skills, and enhance their autonomy in the hierarchical relationships with care recipients, their families, and agencies. Workplace autonomy is also considered a key source of dignity in an occupation often perceived as dirty and undervalued (Kispeter & Hussein, 2026; Stacey, 2005). As a result, training may contribute indirectly to better pay, higher job satisfaction, reduced stress and anxiety, and greater self-efficacy (Kuo et al., 2025; Prosen & Piskar, 2015). Furthermore, knowledge of how to properly use care aids (e.g., lifts) can reduce physical strain and health risks such as back injuries.

However, these benefits remain limited. We found that higher qualifications—especially in language proficiency or complex care tasks—are often associated with more demanding assignments, both physically and emotionally. Many live-ins, particularly older workers, therefore deliberately choose less demanding positions, even if they are lower paid. Furthermore, while formal training can enhance professional recognition, it may also introduce greater distance in relationships with care recipients, potentially conflicting with expectations of closeness and quasi-familial care (Hayes et al., 2019; Lewis & West, 2014; Walsh & Shutes, 2013).

A key limitation of formal training lies in its inability to fully prepare caregivers for the unpredictable, emotionally challenging situations they may experience—particularly in dementia care (Latham et al., 2024, p. 752). One representative of a German employers' association expressed this clearly:

> These dementia situations are challenging….It's easy to say "Stay calm" when we're sitting at our desks. But when I'm standing in front of someone with dementia who suddenly drops their pants, gets angry, or hits me—staying calm is a pipe dream.

Caregivers confirmed this view, noting that each placement is a surprise, regardless of agency-provided descriptions. Patients, households, and health conditions vary widely, requiring caregivers to adapt continuously and rely on informal, on-the-job learning, which makes standardized training inherently limited. As Latham et al. (2024, p. 747) and others argue (Anvik et al., 2020; Eraut, 2004, 2007), practice in care is often guided by the principle "what works is what matters," grounded in everyday interactions with clients, families, colleagues, and agency staff. In this sense, "learning to care is essentially and inevitably learning to care in this particular place" (Latham et al., 2024, p. 757).

Moreover, while formal training addresses certain skill gaps, much learning continues to take place informally—through improvisation, experience, and peer exchange in everyday care situations, as care workers explained during the on-site training in which I participated. One caregiver recounted her experience caring for a dementia patient, noting how much she learned through daily conversations with the patient's daughter:

> We always talked about what the client was doing, reflected on how to react, and so on. During this assignment, I learned the most….You have to observe, you have to do things yourself—you learn it from the people you care for, unfortunately. But I also believe that this kind of knowledge cannot simply be taught from books.

Positive relationships play a pivotal role in live-in care and for the job satisfaction of the caregivers, owing to the intimate and immersive nature of the care arrangement (Cohen-Mansfield & Golander, 2021; Iecovich, 2011). While training can improve care skills, it has limited influence on the quality of care relationships, which often hinge on mutual respect, understanding, and interpersonal "chemistry" (which is often cited in interviews by all parties involved). Thus, training for caregivers alone is insufficient to improve working conditions, as this anecdote of a care worker shows:

> I started at 7 a.m. and often didn't go to bed until 1 or 2 a.m., only when grandmother finally fell asleep….The family also expected me to do everything, even tasks meant for specialists, like speech therapy, which I refused because I'm not trained for that. After she broke her hip, I was even told to handle her mobilization myself, because the family didn't want to pay for her specialist care.

Such accounts highlight that unmet expectations and unclear task boundaries remain central challenges. A lack of awareness regarding caregivers' rights, responsibilities, and limitations often leads to conflicts and overburdening. While mutual training or counselling could help align expectations and improve relationships and working conditions, such initiatives are rarely offered by agencies beyond basic information provision. More fundamentally, the impact of training is constrained by the structural conditions of the unregulated live-in care system, shaped by for-profit agencies and persistent undervaluation of care work.

Finally, our findings suggest that collaboration between live-in caregivers and outpatient services offers a promising way to bridge the gap between formal training and practice. Larger German agencies increasingly integrate outpatient care into their services: Qualified nurses monitor patient health, perform quality checks, and step in when tasks exceed caregivers' competencies. At the same time, nurses provide on-site instruction—for example, in using lifts or medical devices. Many caregivers reported such informal guidance as highly valuable, even when no formal cooperation existed. Others, however, expressed frustration, feeling that they

were expected to take over and perform tasks usually assigned to qualified staff, even though they did not have the legal authority to do so.

9. Conclusion

As this study has shown, training for live-in caregivers is often presented by agencies as a key solution for improving care quality and meeting the expectations of both clients and workers. This framing suggests that a lack of training is the central issue. However, extensive research indicates that the main challenges lie in structural conditions, including precarious employment, low pay, long working hours, and physically and emotionally demanding labor (Aulenbacher et al., 2021, 2024; Grenz & von Kutzleben, 2024; Prieler, 2021), which significantly shape care quality.

At the same time, the emphasis on training must be understood in relation to the business model of transnational brokerage agencies. Operating in a competitive, price-sensitive market, agencies depend on maintaining a flexible workforce while keeping labor costs low. Training thus serves a dual function: It enhances the agencies' competitiveness and signals quality to clients and care workers, without fundamentally altering wage structures or working conditions. This dynamic also explains the emphasis on soft skills such as empathy and adaptability. Although these can be developed through training, they are often framed as personal or culturally embedded traits, allowing agencies to valorize care work without recognizing it as a formally qualified activity that would justify higher pay.

Responsibility for improving conditions is frequently shifted onto policymakers. Agencies argue that better-qualified care workers would require increased public subsidies, thereby externalizing the costs of professionalization. This highlights a fundamental tension between the organization of live-in care as a for-profit market and the goal of ensuring fair working conditions and high-quality care. As long as profitability depends on cost minimization, there are clear limits to professionalization.

At the same time, meaningful improvements require stronger political and societal recognition of care work. In the German labor market, higher qualifications are usually linked to better pay and working conditions (Wirtschafts- und Sozialwissenschaftliches Institut, 2021), yet this does not apply to reproductive labor, particularly migrant care work. As Hochschild (2000) has shown, transnational care arrangements are embedded in global inequalities that devalue care labor while rendering it indispensable. Addressing these inequalities requires not only regulation but also substantial public investment, including stronger enforcement of labor standards and expanded care infrastructure.

The study further highlights the contradictory expectations placed on Polish live-in caregivers. While agencies and families increasingly demand formal skills, caregivers emphasize adaptability, resilience, and practical experience. The specific conditions of live-in care intensify these tensions. Caregivers face isolation, long absences from home, and the need to adapt constantly to individual households. Although agencies offer training and support, these remain limited and often voluntary. The lack of clear legal definitions of tasks and rights complicates the development of standardized training, leading to uneven quality of training. Online formats increase accessibility but cannot fully replace supervised, practice-based instruction. Much learning continues to occur informally through practice, observation, and peer exchange. While training can enhance employability, its impact on working conditions remains constrained by families' limited willingness

or ability to pay higher wages, partly due to insufficient public funding. Thus, for many caregivers, training remains unattractive because it requires time and effort without offering clear or immediate financial returns or improved working conditions.

However, when it is accessible and well-designed, training can enhance both care quality and job satisfaction. Caregivers particularly value opportunities for mental and physical health support, peer exchange, language learning, and greater awareness of their rights, which can strengthen their autonomy and self-efficacy.

In conclusion, a sustainable and just live-in care model requires a holistic approach. Policymakers must establish comprehensive regulatory frameworks, qualification and training standards, effective control mechanisms, financial incentives for qualified caregivers, and closer cooperation between live-in workers and outpatient services, without exposing caregivers to further exploitation. Alternative approaches, including a stronger role for non-profit providers such as Caritas or Diakonie, may help rebalance care quality, worker protection, and affordability. Ultimately, meaningful professionalization depends on aligning regulation, funding, and organizational structures to move beyond cost minimization and recognize care work as an essential part of the social infrastructure.

Acknowledgments

The author would like to thank the anonymous reviewers and editors for their constructive and insightful comments, as well as the individuals who shared their personal experiences with the author and made this study possible.

Funding

The project CareOrg – Researching the Transnational Organization of Senior Care, Labor and Mobility in Central and Eastern Europe (2023–2027; https://careorg.eu) is funded by the Volkswagen Foundation (VolkswagenStiftung). Publication of this article in open access was made possible through the institutional membership agreement between Goethe University Frankfurt and Cogitatio Press.

Conflict of Interests

The author declares no conflict of interests.

Data Availability

The ethnographic data on which this study is based are stored on secure data servers of Goethe University Frankfurt. They are confidential and context-dependent and cannot be shared in accordance with research ethics commitments made to participants.

LLMs Disclosure

ChatGPT and DeepL, run in a secure, university-owned environment, were used only for translations and language and grammar editing, and their outputs were critically revised by the author; the LLM tools did not generate or modify the substantive content of this manuscript.

References

Anvik, C., Vedeler, J. S., Wegener, C., Slettebø, Å., & Ødegård, A. (2020). Practice-based learning and innovation in nursing homes. *Journal of Workplace Learning*, *32*(2), 122–134. https://doi.org/10.1108/JWL-09-2019-0112

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Aulenbacher, B., Lutz, H., & Schwiter, K. (2021). *Gute Sorge ohne gute Arbeit? Live-in-Care in Deutschland, Österreich und der Schweiz*. Beltz Juventa.

Bartova, A., Thaning, M., Van Lancker, W., Backman, L., & Nieuwenhuis, R. (2023). *Family profiles: Risks, resources and inequalities* (rEUsilience Working Paper Series, No. 1). rEUsilience. https://doi.org/10.31235/osf.io/7uaf6

Bolton, S. C. (2009). The lady vanishes: Women's work and affective labour. *International Journal of Work Organisation and Emotion*, *3*(1), 72–80.

Chau, H. S. (2019). Producing (im)mobilities in home care for the elderly: The role of home care agencies in Switzerland. *International Journal of Ageing and Later Life*, *13*(2), 23–50. https://doi.org/10.3384/ijal.1652-8670.18396

Cohen-Mansfield, J., & Golander, H. (2021). Predictors of migrant live-in care workers' burden/burnout and job satisfaction when caring for frail older persons in Israel. *The Journals of Gerontology: Series B*, *76*(6), 1151–1160. https://doi.org/10.1093/geronb/gbaa171

Damant, J., Ettelt, S., Perkins, M., Lorraine, W., Wittenberg, R., & Mays, N. (2023). Facilitators of, and barriers to, personalisation in care homes in England: Evidence from Care Quality Commission inspection reports. *International Journal of Care and Caring*, *7*(1), 91–113. https://doi.org/10.1332/239788221X16426133095792

Eraut, M. (2004). Informal learning in the workplace. *Studies in Continuing Education*, *26*(2), 247–273. https://doi.org/10.1080/158037042000225245

Eraut, M. (2007). Learning from other people in the workplace. *Oxford Review of Education*, *33*(4), 403–422. https://doi.org/10.1080/03054980701425706

Ettelt, S., Damant, J., Perkins, M., Williams, L., & Wittenberg, R. (2020). *Personalisation in care homes for older people*. Policy Innovation and Evaluation Research Unit, London School of Hygiene and Tropical Medicine. https://piru.ac.uk/assets/uploads/files/personalisation-in-care-homes-final-report.pdf

Farris, S. R., & Marchetti, S. (2017). From the commodification to the corporatization of care: European perspectives and debates. *Social Politics: International Studies in Gender, State & Society*, *24*(2), 109–131. https://doi.org/10.1093/sp/jxx003

Gerhards, S., von Kutzleben, M., & Schweda, M. (2022). Moralische Probleme der Versorgung von Menschen mit Demenz durch osteuropäische Live-in-Hilfen: Eine ethische Analyse der Erwartungen von Angehörigen in Onlineforen. *Ethik in der Medizin*, *34*(4), 573–590. https://doi.org/10.1007/s00481-022-00708-8

Glaser, B. G., & Strauss, A. L. (2017). *The discovery of grounded theory: Strategies for qualitative research*. Routledge. https://doi.org/10.4324/9780203793206

Grenz, A., & von Kutzleben, M. (2024). Conceptualisations of good care and conflicts in live-in migrant care arrangements for people with dementia—Perspectives of family caregivers in Germany. *BMC Geriatrics*, *24*(1), Article 702. https://doi.org/10.1186/s12877-024-05283-9

Hayajneh, F. A., & Shehadeh, A. (2014). The impact of adopting person-centred care approach for people with Alzheimer's on professional caregivers' burden: An interventional study. *International Journal of Nursing Practice*, *20*(4), 438–445. https://doi.org/10.1111/ijn.12251

Hayes, L., Johnson, E., & Tarrant, A. (2019). *Professionalisation at work in adult social care: Report to the All-Party Parliamentary Group on Adult Social Care*. GMB Trade Union. https://kar.kent.ac.uk/77269/1/Professionalisation_at_Work_0309.pdf

Hess, S. (2002). Au Pairs als informelle Haushaltsarbeiterinnen—Flexibilisierung und Ethnisierung der

Versorgungsarbeiten. In C. Gather, B. Geissler, & M. S. Rerrich (Eds.), *Weltmarkt Privathaushalt. Bezahlte Hausarbeit im globalen Wandel* (pp. 103–119). Westfälisches Dampfboot.

Hochschild, A. R. (1985). *The managed heart: Commercialization of human feeling*. University of California Press.

Hochschild, A. R. (2000). Global care chains and emotional surplus value. In A. Giddens & W. Hutton (Eds.), *On the edge: Living with global capitalism* (pp. 130–146). Jonathan Cape.

Hryciuk, R. E., & Korolczuk, E. (2012). *Pożegnanie z Matką Polką? Dyskursy, praktyki i reprezentacje macierzyństwa we współczesnej Polsce*. Wydawnicto Uniwersytetu Warszawskiego. https://doi.org/10.31338/uw.9788323511175

Iecovich, E. (2011). What makes migrant live-in home care workers in elder care be satisfied with their job? *The Gerontologist*, *51*(5), 617–629. https://doi.org/10.1093/geront/gnr048

Ivancheva, M., & Keating, K. (2020). Revisiting precarity, with care: Productive and reproductive labour in the era of flexible capitalism. *Ephemera: Theory & Politics in Organization*, *20*(4), 251–282.

Kispeter, E., & Hussein, S. (2026). Combining professionalization and personalization in English long-term care: Analyzing stakeholder views through a workforce lens. *Frontiers in Sociology*, *10*, Article 1719789. https://doi.org/10.3389/fsoc.2025.1719789

Krawietz, J. (2014). *Pflege grenzüberschreitend organisieren: Eine Studie zur transnationalen Vermittlung von Care-Arbeit*. Mabuse.

Kuo, T.-S., Chu, L.-C., Shih, C.-L., Li, Y.-C., & Kao, P.-L. (2025). Emotional labor, job satisfaction, and retention among home care workers in Taiwan: A comprehensive analysis. *Frontiers in Psychology*, *16*, Article 1545955. https://doi.org/10.3389/fpsyg.2025.1545955

Latham, I., Brooker, D., & de Vries, K. (2024). How do care workers learn to care for people with dementia living in care homes? A model of informal learning. *Journal of Workplace Learning*, *36*(8), 746–769. https://doi.org/10.1108/JWL-04-2024-0080

Leiber, S., Rossow, V., Österle, A., & Frerk, T. (2021). Yet another black box: Brokering agencies in the evolving market for live-in migrant care work in Austria and Germany. *International Journal of Care and Caring*, *5*(2), 187–208. https://doi.org/10.1332/239788220X15988973352874

Lewis, J., & Giullari, S. (2005). The adult worker model family, gender equality and care: The search for new policy principles and the possibilities and problems of a capabilities approach. *Economy and Society*, *34*(1), 76–104. https://doi.org/10.1080/0308514042000329342

Lewis, J., & West, A. (2014). Re-shaping social care services for older people in England: Policy development and the problem of achieving "good care." *Journal of Social Policy*, *43*(1), 1–18. https://doi.org/10.1017/S0047279413000561

Lutz, H., & Benazha, A. V. (2020). Transnationale soziale Ungleichheiten: Migrantische Care- und Haushaltsarbeit. In A. Biele Mefebue, A. Bührmann, & S. Grenz (Eds.), *Handbuch Intersektionalitätsforschung*. https://doi.org/10.1007/978-3-658-26613-4_36-1

Lutz, H., & Palenga-Möllenbeck, E. (2010). Care work migration in Germany: Semi-compliance and complicity. *Social Policy and Society*, *9*(3), 419–430. https://doi.org/10.1017/S1474746410000138

Lutz, H., & Palenga-Möllenbeck, E. (2011). Care, gender and migration: Towards a theory of transnational domestic work migration in Europe. *Journal of Contemporary European Studies*, *19*(3), 349–364. https://doi.org/10.1080/14782804.2011.610605

Manthorpe, J., Harris, J., Samsi, K., & Moriarty, J. (2017). Doing, being and becoming a valued care worker: User and family carer views. *Ethics and Social Welfare*, *11*(1), 79–91. https://doi.org/10.1080/17496535.2016.1247904

Nyssen, S. (2024). Becoming/being a care worker: Personality in a language training for migrant job seekers

in Flanders. *International Journal of the Sociology of Language*, *2024*(285), 55–71. https://doi.org/10.1515/ijsl-2023-0033

Palenga-Möllenbeck, E. (2024). Divided Europe? The role of home care agencies from Poland, and how the ideal of Decent Work gets lost along tansnational value chains. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (23–36). Sage.

Palenga-Möllenbeck, E., & Fiebig-Spindler, R. (2025). Emerging home care markets in Central and Eastern Europe: Transformations of senior care, labour mobility, and housing in Poland and Germany. *Berliner Journal für Soziologie*, *35*, 549–564. https://doi.org/10.1007/s11609-025-00579-y

Pfeil, W. J., Reichel, A., & Urnik, S. (Eds.). (2020). *Pflege und Betreuung—Who cares?* MANZ'sche Verlags- und Universitätsbuchhandlung.

Prieler, V. (2021). 'The good live-in care worker': Subject formation and ethnicisation in Austrian live-in care. *Sociológia – Slovak Sociological Review*, *53*(5), 483–501. https://doi.org/10.31577/sociologia.2021.53.5.18

Prosen, M., & Piskar, F. (2015). Job satisfaction of Slovenian hospital nursing workforce. *Journal of Nursing Management*, *23*(2), 242–251. https://doi.org/10.1111/jonm.12121

Rösler, U., Nguyen, D., Skwarek, A., Wegge, J., & Melzer, M. (2023). *Arbeit in der häuslichen Betreuung I: Menschen und Arbeitssituationen*. Bundesanstalt für Arbeitsschutz und Arbeitsmedizin. https://doi.org/10.21934/baua:fakten20230929

Sobiesiak-Penszko, P. (2015). *Niewidzialna siła robocza. Migranci w usługach opiekuńczych nad osobami starszymi*. Instytut Spraw Publicznych. https://www.isp.org.pl/pl/publikacje/niewidzialna-sila-robocza

Stacey, C. L. (2005). Finding dignity in dirty work: The constraints and rewards of low-wage home care labour. *Sociology of Health and Illness*, *27*(6), 831–854. https://doi.org/10.1111/j.1467-9566.2005.00476.x

Theobald, H. (2018). Care: Ansätze und Perspektiven der international vergleichenden Geschlechterforschung. In B. Kortendiek, B. Riegraf, & K. Sabisch (Eds.), *Handbuch Interdisziplinäre Geschlechterforschung*. https://doi.org/10.1007/978-3-658-12500-4_70-1

Walsh, K., & Shutes, I. (2013). Care relationships, quality of care and migrant workers caring for older people. *Ageing & Society*, *33*(3), 393–420. https://doi.org/10.1017/S0144686X11001309

Weicht, B. (2011). Embodying the ideal carer. *International Journal of Ageing and Later Life*, *5*(2), 17–52. https://doi.org/10.3384/ijal.1652-8670.105217

Wirtschafts- und Sozialwissenschaftliches Institut. (2021, March 30). *Diese fünf Faktoren bestimmen Ihr Gehalt* [Press release]. https://www.wsi.de/de/pressemitteilungen-15991-diese-funf-faktoren-bestimmen-ihr-gehalt-31863.htm

Wojczewski, S., Ernst, A., Bagheri, R., & Adler, V. (2023). *MigraCare—Weiterbildungsbedarf bei 24-Stunden-Betreuer*innen in Österreich. Ergebnisse einer Online-Umfrage 2023*. MigraCare. https://ois.lbg.ac.at/wp-content/uploads/sites/24/2024/03/MigraCare-Umfrage-Endbericht-0.2.pdf

About the Authors



Roxana Fiebig-Spindler (MA) is a research assistant in the international CareOrg project at the Institute of Sociology, Goethe University Frankfurt. Since her master's thesis in cultural anthropology, she has researched migrant care work, focusing on Polish care workers in Germany. Her research interests include migration, care, and social inequalities.

Social Inclusion
2026 • Volume 14 • Article 11953
https://doi.org/10.17645/si.11953

cogitatio

ARTICLE

Open Access Journal

The Invisible Hand of Care: A Typology of Brokerage Actors in Migrant Care Labour

Ewa Palenga-Möllenbeck [1], Ivanna Kyliushyk [2], and Roxana Fiebig-Spindler [1]

[1] Institute of Sociology, Goethe University Frankfurt, Germany
[2] Centre for Research on Social Change and Human Mobility, Kozminski University, Poland

Correspondence: Ewa Palenga-Möllenbeck (epalenga@uni-frankfurt.de)

Submitted: 16 January 2026 **Accepted:** 18 May 2026 **Published:** 22 June 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Providing senior care is one of the most pressing challenges in a rapidly ageing Europe, particularly in the Central and Eastern European region, which remains largely a care-sending area. Poland has emerged as a trans-European hub for long-term care, acting as a sending, receiving, and transit country, driven by commercial and non-commercial migrant brokerage. Brokerage actors play a central role in facilitating the employment of live-in care workers across Europe. In this article, we present an empirical typology of brokerage actors in the care sector, categorising them according to two dimensions: formalisation and commodification. This typology captures a broad range of actors, from informal migrant networks and individual brokers, through semi-formal actors such as self-organised caregiver groups and social media platforms, to formalised institutions such as civil society organisations, public employment offices, and commercial agencies. Using this typology, we examine how and why formalised informality is increasing within the care economy, under what circumstances, and with what consequences for carers' working conditions. While marketisation has introduced formalising effects on enterprises and labour relations, this is not a one-way path towards decent work. Rather, formalisation itself often generates new forms of informal practices and precarities.

Keywords

brokerage actors; Central and Eastern Europe; (de)commodification; Germany; (in)formalisation; migrant workers; Poland; senior care; Ukraine

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Traditionally, the formalisation of work has been synonymous with decent work, as it implied employment contracts, social security coverage, stable wages, and compliance with labour standards that protect workers' rights. Over the past 15 years, driven by Europe's rapid ageing, the migrant live-in care sector has gained social significance and undergone gradual formalisation (Aulenbacher et al., 2024). However, informal work remains dominant, taking multiple evolving forms. Recent multi-crises, including the Covid-19 pandemic and the full-scale invasion of Ukraine in 2022, have permanently reshaped transnational care organisation in the Central and Eastern European (CEE) region (Ezzeddine, 2024). The pandemic disrupted transnational care chains as mobility restrictions prevented established circular mobility, resulting in acute labour shortages. This accelerated the digitalisation and marketisation of care, and strengthened the legitimacy of brokering agencies, which temporarily regularised workers' status and entered public debates (Palenga-Möllenbeck, 2024a). The war in Ukraine further destabilised these arrangements, as temporary protection for Ukrainian refugees enabled intra-EU mobility and labour market access, while the temporary nature of this status reinforced instability in transnational care provision.

Providing senior care is one of the most important challenges in Europe, especially in the CEE area, which remains largely a care-sending region. Poland currently has the features of an important trans-European hub for long-term care, as it simultaneously exports Polish care workers to countries such as Germany, attracts Ukrainian migrants to provide live-in care in Poland, and serves as a transit country for migrant carers moving onward to Germany and other European destinations. Within this system, the brokerage of migrant workers has become a pivotal mechanism facilitating the reception, transit, and employment of live-in care labour across Europe. However, despite growing research on the commercialisation of home care, less attention has been paid to how diverse brokerage actors operating across formal and informal spheres shape transnational care labour markets.

In this article, we propose an empirical typology of actors brokering the care workforce to, from, and via Poland, thereby contributing to debates on (de)commodification and (in)formalisation of transnational care labour. In the case of Polish care workers being sent to Germany, we observe that previously informal intermediaries have been gradually replaced by new formal economic actors, creating new transnational value chains (Palenga-Möllenbeck, 2024b). By contrast, care brokerage between Ukraine and Poland has a hybrid character, whereby informal and formal intermediation are developing simultaneously. We examine why and how the care economy exhibits both increasing "formalised informality" and persistent informality. While commercialisation promotes businesses and employment formalisation, it does not necessarily improve migrants' working conditions. New forms of informality and precarity are emerging not only despite formalisation, but also because of it. At the same time, informality remains an integral part of brokerage and may also produce de-commodifying effects. These emerge through friendship-based job sharing, solidarity networks complementing trade union representation, and the everyday practices of commercial agencies and non-commercial welfare organisations that mediate between informal and formal, as well as paid and unpaid transnational care provision.

The article is structured as follows: First, we outline key theoretical concepts related to commercially brokered migrant care work. Next, we introduce the mobility context, distinguishing between East–West mobility (sending care workers from and via Poland) and East–East mobility (recruitment from Ukraine). This

is followed by an explanation of our methodology. The empirical section presents a typology of brokerage actors, and the final section discusses the main findings and conclusions.

2. Formalising Care: Theoretical Discussion

Commercially brokered migrant care labour has become a core component of European senior care systems (Aulenbacher et al., 2024). Brokers occupy a central position within migration infrastructures (Xiang & Lindquist, 2014), operating as both informal networks and formalised actors (Faist, 2014) whose intermediation practices span recruitment, matching, and employment. While formal and informal brokerage coexist in transnational live-in care, formal agencies are increasingly driving sectoral formalisation through business practices and policy lobbying. Despite diverse organisational models, brokers share a common logic of recruiting labour from poorer regions to address shortages in wealthier ones (Aulenbacher et al., 2024).

Drawing on the transnational value chain framework (Palenga-Möllenbeck, 2024b), we conceptualise brokerage as the processing of care labour that creates value within markets embedded in intersecting care, labour, and migration regimes, shaped by policy configurations and regulatory gaps (Bruzelius & Shutes, 2022; Lutz, 2025; Lutz & Palenga-Möllenbeck, 2011). In doing so, we ground our typology in multilevel and intersectional approaches to care migration and shed light on migrant brokers as "assemblers," with ambiguous and overlapping roles, functions and motives (Koster, 2019) and on a "linked ecology" (Bastide & Yeoh, 2025) of actors, infrastructures, practices, and brokers who transcend the boundaries of formality, economic calculation and functions. Thus, our typology draws on an ever-expanding body of research on brokerage in care migration, bringing together various dimensions of different typologies: It builds on the role of informal placement through networks and migrant communities in irregular care migration (Ambrosini, 2017); it considers the first cross-country systematisation approach to the commodification, marketisation, and corporatisation of senior care provision proposed by Farris and Marchetti (2017; for a typology of the formalisation of domestic and care work through agencies around the world see also Fudge & Hobden, 2018); and it brings into focus a new actor—digital intermediaries such as labour platforms. The first typology of brokers in the Polish-German care market also highlights the key role of these actors in shaping working standards (Leiber et al., 2019). The editors of the book *Home Care for Sale: The Transnational Brokering of Senior Care in Europe* note soberly that across Europe a trend can be observed whereby, regardless of employment models and the profit orientation of companies, there is less of a linear correlation with working conditions than might be expected (Aulenbacher et al., 2024). While formalisation was expected to improve care workers' conditions (Yeates, 2009), this has proven overly optimistic. We want to answer the question of why this is the case by examining three perspectives on work: its informalisation, its marketisation, and the intersectional characteristics of outsourced domestic work.

Informalisation is a relative, broad, and heterogeneous concept (Evans & Tilly, 2015), particularly in cross-regional analyses. Transdisciplinary labour studies conceptualise informal work through the analytical dimensions of economies, their actors and practices, and their characteristics—whether at the level of industries, enterprises, or employment relations. Formal employment is commonly divided into two types, waged and self-employment; however, the literature identifies numerous subcategories within each (Chen, 2015, p. 409). The informalisation of work has multiple causes, and the globalised division of labour produces flexible specialisation and subcontracting chains—phenomena also evident in our field (Chen, 2015). Recent debates highlight the global, cross-sectoral expansion of informalisation and the

heterogeneity of its forms. As observed in our field, the boundaries between informal and formal work are increasingly blurred by the growth of non-standard employment (Palenga-Möllenbeck, 2024b). Informalisation is also linked to the digitisation and platformisation of work, whereby labour rights are often constrained by selective and limited forms of formalisation, even when care platforms introduce regulations (Strüver, 2021, p. 107). Non-standard labour in transnational live-in care thus reflects broader challenges debated in labour studies, including shifting dichotomies such as workers' autonomy vs control, social protection vs risk, and flexible vs rigid regulation. These developments also have significant implications for how "decent work"—traditionally associated with stable employment, fair remuneration, and reliable security—is being reinterpreted.

Feminist theories of work conceptualise care as part of an expanded notion of labour, encompassing unpaid and informal reproductive work that is rendered socially invisible and systematically undervalued through the naturalisation of a binary gender order (Becker-Schmidt, 2004). Constructed as female, care is situated at the intersection of family obligation, formal employment, and semi-professional labour. Research in the sociology of professions further shows that gender shapes professional hierarchies, from informal attributions of competence to formal criteria of recruitment (Wetterer, 2017). While attempts to formalise paid domestic care are yet to be integrated into a coherent theoretical framework, the literature so far agrees that standardisation and professionalisation generate structural paradoxes, particularly regarding the emotional and regulatory dimensions of care work.

Tronto's (1989) distinction between "caring for" and "caring about" exposes a tension between expectations of empathy and the professional norm of emotional distance, whereby proximity is devalued and detachment framed as competence, a dynamic echoed in Waerness's (1984) contrast between holistic and transactional care models. These tensions are further intensified by the household as a contested site of living and working, captured by Folbre's (2001) concept of "prisoners of love," where emotional attachment coexists with systematic undervaluation and exploitative conditions.

Brokered live-in care exemplifies how "externalization societies" (Lessenich, 2016) respond to the care crisis much as they once did to labour shortages: by recruiting workers from less prosperous countries, for whom care work abroad often offers a desirable alternative and sometimes an escape from precarious living conditions. Within the CEE region, this form of "care extractivism" rests on a historical East–West hierarchy and is shaped by structural exclusions and inclusions mediated through EU citizenship rights (Lewicki & Probst, 2025; Uhde, 2024). Moreover, several CEE countries are not only "exporters" of care workers but have also begun to externalize care costs themselves. They are thus emerging as destinations for migrant care labour and positioning themselves as "semi-peripheries" within the trans-European care economy (see Hrženjak, 2026). Debates on the international division of labour between central and peripheral regions are increasingly moving away from framing the conflict between labour and capital simplistically as a zero-sum game, without espousing "win–win" narratives that are overly optimistic about the consequences for the periphery (such as the global South and, by extension, Eastern Europe). In the final analysis, the capitalist economy still deepens the care crisis by rendering reproductive labour—essential to capitalist production—invisible, while reinforcing labour divisions based on gender, class, and ethnicity (Fraser, 2022).

Although the commodification and marketisation of care and health have been embedded in the EU's framework of "new economic governance" since 2008 (Stan & Erne, 2024), these developments have been

widely critiqued as short-term capitalist responses that deepen inequalities. Dowling (2021, p. 15) describes this dynamic as "care fixes," capturing the reorganisation of production, reproduction, and care relations through policies that marketise care and recast citizens as consumers in welfare markets. While commodification and marketisation of care work are the dominant trends, the opposite tendency of de-commodification is also relevant to our case study. Both concepts derive from Esping-Andersen's (1990) understanding of welfare regimes and refer to the extent to which individuals' or families' welfare either depends on the market (commodification) or is secured by the welfare state, civil society, or families (de-commodification).

3. Context

The organisation of care migration from Ukraine to Poland and from Poland to Germany, as well as the emerging transnational live-in care markets, reveal both commonalities and divergences shaped largely by the distinct geopolitical trajectories of Poland and Ukraine in recent decades.

3.1. East–West Mobility: Posting Care Workers From and Via Poland

In the early 1990s, economic restructuring prompted Polish women to commute to Germany for work. Visa restrictions fostered a rotation-based migration system that relied heavily on informal channels such as word-of-mouth and Polish community networks (e.g., churches). Following Poland's EU accession in 2004, transitional restrictions limited access to the German labour market until 2011, allowing only self-employment or service provision via Polish-based companies. Together with rising demand for senior care, this facilitated the emergence of transnational care agencies.

Today, the posting model dominates: Around two-thirds of agencies based in Germany and 90% of those in Poland operate under this scheme, self-employment remains secondary (10–15% of German and 5% of Polish agencies), and regular employment plays only a marginal role (Palenga-Möllenbeck, 2024b). In this model, workers are employed in the sending country and posted under the EU freedom to provide services, within a complex legal framework combining national regulations and EU law (including the Services Directive and ECJ rulings), so that the labour law of the sending country applies, while selected host-country standards, such as working time and rest periods, must be respected.

The system has expanded to include third-country nationals legally residing in the EU, with Polish agencies specialising in posting such workers and using the Polish labour market as a springboard. As a result, Poland has become a "trans-European hub" for carers not only from Poland but also from Croatia, Slovenia, the Czech Republic, Romania, and primarily Ukraine.

This mirrors a key feature of the Polish labour market regime, which involves outsourcing work and its regulations to temporary work agencies and, at the same time, Poland's leading role in the EU in recruiting third-country nationals for temporary labour markets (Matuszczyk & Kowalska, 2024, p. 6).

In Poland, posted carers are usually employed under "civil-law contracts" outside labour law, shifting risks of unemployment, illness, pregnancy, and old age onto workers. Although a minimum wage was introduced in 2017, working hours are often negotiated informally with households, which hold significant power despite

not being formal employers. Standby time and shared activities are frequently excluded from working time. Due to blurred boundaries between work and private life and the legal inviolability of the home, actual working hours often diverge from contracts, and inspections are virtually impossible.

Since the mid-2000s, brokerage has become increasingly professionalised, transnational, and digitally mediated. The number of agencies expanded rapidly: from 30 companies in Germany in 2007 to 337 in Germany and 190 in Poland offering live-in care services to Frankfurt alone in 2017. While German agencies focus on client management and conflict mediation, Polish agencies, as primary contractors, carry most operational responsibilities, including recruitment, administration, transport, training, and worker support. Given limited regulation, agencies have assumed a quasi-regulatory role, setting standards and practices themselves.

3.2. East–East Mobility: Recruiting Care Workers From Ukraine

Although the live-in care sector in Poland is relatively recent, rapid population ageing has generated increasing demand. Despite its growing importance, the sector largely operates within the grey economy, characterised by informal employment, unstable working conditions, and limited social protection (Kałuża-Kopias, 2018). It is highly feminised, shaped by traditional gender roles and labour market structures that channel women into low-paid and precarious care work (Fedyuk et al., 2023). Insufficient institutional support and limited public funding further constrain the sector, which remains underdeveloped and poorly prepared for future demographic challenges.

The absence of comprehensive reforms has contributed to persistent labour shortages. Polish workers increasingly prefer better-paid and more regulated jobs abroad, particularly in Germany, while migrants are more likely to accept caregiving jobs in Poland despite precarious conditions (Kałuża-Kopias, 2018). From its outset, the Polish home care market has depended strongly on transnational mobility, especially circular migration between Ukraine and Poland (Kindler, 2008). Estimates suggest that between 70,000 and 100,000 Ukrainian women work in the domestic sector in Poland (Klakla et al., 2023), the majority of whom are employed irregularly (Rogalewski & Florek, 2020). Poland also functions as a transit corridor for onward migration from Ukraine to other European countries, complicating assessments of the actual scale of employment in care.

The most dynamic changes occurred after 2022, with Russia's full-scale invasion of Ukraine and the granting of temporary protection status to Ukrainian forced migrants in Poland. While this provided access to selected social rights, including healthcare, it did not contribute to a reduction in irregularity in the care sector.

Ukrainian migration into Poland's domestic care sector began in the 1990s, enabled by post-Soviet border openings and the 1993 visa-free regime (Kyliushyk & Chról, 2025). It initially relied on informal networks with limited institutionalised intermediation. After Poland's EU accession in 2004, small agencies emerged in response to growing demand for senior care, often operating in a grey zone, while employment remained largely irregular. Following the 2014 war in eastern Ukraine and the reintroduction of visa-free travel in 2017, Poland became the primary destination for Ukrainian women, and brokerage diversified through agencies and online platforms, although standard contracts remained rare (Kałuża-Kopias, 2018).

Polish agencies increasingly recruit Ukrainian migrants already present in Poland, and brokerage has become more digitalised via social media and embedded in migrant networks (Kindler & Szulecka, 2022). In the absence of clear legal regulation, much of the sector continues to operate in the grey economy, with agencies assuming quasi-regulatory roles.

4. Methodology

This article draws on two research projects and one PhD study. The first project, Decent Care Work (2017–2021), examined the transnational brokerage of migrant care workers into private households in Germany, Austria, and Switzerland. We refer to 42 interviews conducted in Poland and Germany between 2017 and 2020. These included expert interviews with employers' organisations, employee-oriented counselling centres, employers' associations, and representatives of brokerage agencies based in Germany and Poland, and semi-structured interviews with care workers, family members, and relatives of care recipients. The second project, CareOrg (2023–2026), is investigating the processes of marketisation and the transnational organisation of senior care in the CEE area. The main data analysed here stem from interviews conducted in Germany, Poland, and Ukraine between 2024 and 2025. These included interviews with: five representatives of Polish brokerage agencies and eleven employees from five different Polish agencies, two representatives of Polish employers' associations, two trade union representatives, one representative from a Polish counselling centre, and two Polish researchers; a focus group discussion was conducted with six Polish care workers following an on-site training session organised by a Polish agency. Further interviews were carried out with five representatives of German brokerage agencies, one representative of a non-profit organisation, and two representatives of German employers' associations. Ten semi-structured interviews were conducted with key actors involved in the transnational care sector between Poland and Ukraine: six care workers and four brokers, including a representative of a brokerage agency, a Ukrainian-born moderator of a large Facebook group used for informal job brokerage in care work, a self-employed broker from Ukraine operating as a registered business, and an informal broker from Ukraine who facilitates employment and door-to-door transportation to the workplace. Additional data was drawn from the PhD project of Roxana Fiebig-Spindler, which included interviews conducted between 2020 and 2022 with the owner of a German agency, four employees from two agencies, and sixteen interviews with thirteen Polish care workers. Accessing and conducting research with agencies presented notable challenges. While some were open to collaboration, others were harder to reach, often citing research fatigue or prior negative experiences, and perceiving researchers as fundamentally critical. Recruiting brokers for Ukrainian women working in Poland was difficult, as many operated semi-formally or informally and were reluctant to participate. Access was gradually achieved through desk research, personal requests, snowball referrals, and engagement with online caregiver communities. In contrast, arranging interviews with caregivers was easier, facilitated by personal networks of the authors of this article, snowballing, and support from a care workers' organisation.

Most interviews were conducted in the interviewees' native languages, facilitating trust-building and ensuring the depth and authenticity of the data. This proved especially relevant given the vulnerable and often precarious position of the care workers. Transcripts were analysed using MAXQDA software, following the methodological steps of grounded theory (see Müller & Skeide, 2018) and thematic analysis, which enabled the identification of cross-cutting patterns.

5. Typology of Brokerage Actors in the Care Sector

In this section, we present the results of our analysis of brokerage of migrant care work, focusing on the CEE area with empirical reference to Poland as a sending, receiving, and transiting country for migration. We propose a typology of brokers in the care sector (see Table 1) that distinguishes between different types of brokerage according to two dimensions: their degree of formalisation (formal, semi-formal, or informal) and commodification (not-for-profit or for-profit). This captures a spectrum of actors, ranging from migrant networks and individual brokers operating informally, through semi-formal arrangements such as self-organised groups of caregivers or social media platforms, to formalised institutions including civil society organisations and commercial agencies.

However, these categories should not be understood as fixed or mutually exclusive. Brokerage actors frequently operate across and between these positions, combining formal and informal, commercial and non-commercial, and legally regulated and unregulated practices. In this sense, our typology should be understood as an analytical tool for identifying dominant organisational logics and practices rather than as a strict classification of empirically separate actors. As Koster (2019) argues, brokerage often functions through overlapping and assembled arrangements shaped by intersecting economic, political, and social rationales. Accordingly, actors in the care sector continuously navigate and combine multiple brokerage roles within a dynamic and unregulated transnational care market.

Table 1. Typology of brokerage actors in the care sector.

Commodification /Formality	For-profit	Not-for-profit
Informal	Individual brokers	Migrant networks
Semi-formal	Online group facilitators and job platforms	Self-organised communities of caregivers
Formal	Agencies and other business entities	Civil society and public institutions

Even though all brokerage types may operate across both migration contexts, important differences emerge between East–West and East–East mobility. Formal for-profit agencies based primarily in Poland and Germany are particularly dominant in the posting of Polish and increasingly Ukrainian care migrants to Germany, whereas the recruitment of Ukrainian women into the Polish care sector relies more strongly on hybrid and informal forms of brokerage, often organised through transnational migrant networks, individual brokers, and social media-based intermediation operating between Ukraine and Poland. By systematising these diverse forms of brokerage, the typology sheds light on the multiple and often overlapping mechanisms through which migrant workers access employment in the care sector.

5.1. Migrant Networks: Informal Non-Profit Actors

As most care workers engaged in transnational care in Poland and Germany are employed informally, personal networks play a crucial role in facilitating migration and job placement and serve as a primary source of information. Caregivers often prefer informal brokerage due to higher expected earnings, greater accessibility and flexibility, and mistrust towards recruitment agencies associated with unclear or exploitative practices. Informal arrangements involve fewer bureaucratic barriers and rely on trusted ties between relatives, friends, or acquaintances. While previously organised mainly face-to-face, such

non-profit brokerage is now increasingly mediated online and embedded in shared migratory experiences and mutual support. The following account of a Ukrainian caregiver working in Poland illustrates how care work circulates through these informal, transnational connections:

> I find work mostly through friends. It's mostly through women I know who work in caregiving. One woman tells another about available work, and someone goes home. When I first came to Poland, I called my relative, who already had several contacts with Ukrainian women. I wrote down their numbers. So, the circle of acquaintances grew. It's all done over the phone. And that's how we find the work. (care worker_5)

While informal non-profit job brokerage offers advantages such as flexibility, autonomy, and access through trusted networks, it is not without its challenges. One of the most pressing issues is the lack of enforceable labour protections. The work brokers organise is completely undeclared or underdeclared—for example, by relying on EU tourist health insurance—bringing with it all the negative consequences. Employers are often reluctant to formalise employment relationships, even when explicitly asked to do so by caregivers. As a result, the scope of duties remains vague and easily expandable, which frequently leads to exploitation. Migrant women are left without effective mechanisms to defend their rights or negotiate the terms of their work. Job loss in this context entails starting the entire search process anew, often under conditions of financial stress. Moreover, the constant risk of being replaced by another worker willing to accept lower pay or more duties creates additional insecurity within these networks.

5.2. Individual Brokers: Informal For-Profit Actors

Paid informal brokerage existed earlier and was typically mediated by a "former acquaintance," without contracts and involving payments from both employers and workers. A prominent example was the so-called "bus driver" model in Ukrainian migration to Poland. From the 1990s, these intermediaries—usually men—developed transnational networks, providing entirely informal yet multifaceted services, including job placement, visa facilitation, door-to-door transport, and conflict mediation. Operating on a commission basis, driver-intermediaries initially played a key role in agriculture but later expanded into manufacturing and care work. Over time, they also began receiving job offers from recruitment agencies and migrant women themselves, particularly those seeking a replacement or sharing job leads. Despite their significance, this form of intermediation has been criticised for its lack of transparency and exploitative potential, and its relevance declined with the introduction of visa-free travel and the consolidation of informal migrant networks:

> Well, first of all, they can promise to bring someone, even to factories or plants, but I even talked to several drivers…to see if they personally know the employers, how it actually works. Well, no, they don't know anything personally, they don't know….They just get a certain amount per person, and after a month of work, they receive this money, for example. And I know many people who ended up in not very good situations, endured it, and in the end earned nothing and went on looking for better jobs. So, in my opinion, they haven't built a very good reputation. Again, it's only for the purpose of profit. (Facebook care workers group coordinator_2)

In the case of Polish migration, drivers are partially part of the sector and are more formalised, sometimes cooperating with agencies.

Other informal, individual for-profit brokers operate locally and provide only matching services. Notably, many care workers refer to these brokers as "agencies," even when their mode of operation differs markedly from that of formal agencies. Closer examination often reveals that such an "agency" is in fact a single person—usually a woman—whose name circulates informally among migrants. Caregivers typically have no written contract with these intermediaries, and wages are usually paid directly by the employer rather than through the broker. Despite the informality of these arrangements, such brokers retain considerable influence in connecting employers and caregivers, as one care worker described:

> I don't know the address. The company is just called "Justyna" [the name has been changed]—run by a lady. I have her phone number, and that's where I call….I heard about it through our diaspora. Someone gave me the phone number and said there's this agency. (care worker_6)

One of these individual brokers confirms this approach, stating that it is a central point of contact and obviously receives many offers from job seekers: "Most caregivers find me themselves. Acquaintances through acquaintances. Of course, I post announcements on Facebook" (informal broker_3).

The most frequently mentioned advantage of working with individual brokers is that the cooperation does not resemble traditional agency-based employment. A key point of distinction lies in the financial arrangement: Caregivers emphasise that no one profits directly from their labour. In most cases, the broker is paid a one-time fee by the employer for matching them with a caregiver, while the worker receives their full wage directly from the household. Despite the practical advantages that this model of private intermediation offers to caregivers, it does not lead to formal employment or greater protection of their labour rights. As our interviewees reported, they are often responsible for negotiating the terms of their work on their own, including fundamental issues such as the scope of duties and securing at least one day off per week.

5.3. Online Group Facilitators and Job Platforms: Semi-Formal For-Profit Actors

Among semi-formal for-profit actors, coordinators of large online caregiver communities—most notably Facebook groups—play a prominent role as platforms for job searching. Moreover, in Germany, we now also find traditional job platforms that place live-ins in households (e.g., marta.de). Some of these groups attract tens of thousands of members; for example, at the time of our study, the largest Ukrainian group in Poland had 50,848 members, while the largest Polish group in Germany exceeded 100,000 members. Operating with minimal or no regulation, these communities constitute a semi-formal form of labour intermediation and are used by a wide range of brokers, from individual informal intermediaries to large agencies. In exchange for a fee, coordinators post job advertisements on behalf of both informal and formal actors, often extending recruitment beyond the Polish labour market to other EU countries, thereby blurring the boundaries between informal and formal brokerage.

While primarily used for job intermediation, these social media groups also function as spaces for information exchange, collective orientation, and emotional support among caregivers. They enable users to assess wage levels, job responsibilities, and working conditions, as well as to share experiences and strategies for asserting boundaries. In this way, the same digital spaces simultaneously facilitate for-profit brokerage and non-profit practices, combining labour market mediation with mutual support:

> These topics [discussions about rates] are constantly discussed [in a Facebook group moderated by the interviewee]. And now caregivers even ask before agreeing to a certain job: "How much should I ask for this service?" So they exchange information all the time….That is, any information on how long one can stay during the war on the territory of Poland, whether you need to leave Poland, or whether insurance is needed now to cross the border….They [women] start sharing information and experiences…teaching each other how to defend their personal boundaries. (Facebook care workers group coordinator_2)

Another example is often reported by care workers of agencies having conflicts with German clients about the amount of food provided in the client's household to the care worker. Even though regulations regarding meal provisions exist in German law, some agencies and clients do not ensure caregivers receive adequate nutrition, and caregivers are often left uninformed by their agencies about their rights and the actual value of the food provisions. One of the caregivers we interviewed mentioned that she could rely on an informal solidarity group on Facebook, where information on regulations was shared so that she could better navigate this conflict.

Although social media has become one of the central infrastructures of job intermediation in the care sector, its role extends well beyond simple job matching. By circulating information on pay rates, working conditions, and mutual expectations, these platforms actively shape informal labour norms and everyday understandings of rights and obligations. At the same time, however, they do not provide effective safeguards against exploitation. In this way, being located at the intersection of informal and semi-formal arrangements and operating across both non-profit and for-profit logics, social media platforms overlap and combine different brokerage roles.

5.4. Self-Organised Communities of Caregivers: Semi-Formal Non-profit Actors

In the absence of a comprehensive regulatory framework protecting the rights of domestic care workers, the responsibility for negotiating working conditions and defending labour rights has increasingly fallen on the caregivers themselves. Given the lack of established sectoral trade unions specifically dedicated to migrant domestic and care workers in Poland, grassroots initiatives created by caregivers themselves have begun to assume functions associated with labour representation, advocacy, and informal worker protection. In this context, mechanisms of self-organisation and grassroots empowerment have emerged as critical strategies of collective advocacy. A significant step toward institutionalising such efforts was the establishment of the Workers' Initiative Commission for Domestic Workers at the All-Poland Trade Union (hereafter: the Commission), initiated by Ukrainian women themselves at the end of 2021.

This group represents a pioneering effort to create a support infrastructure specifically targeting migrant domestic workers, particularly caregivers. It provides vital services including access to legal and psychological assistance, consultation on legalisation procedures, and dissemination of informational materials about workers' rights. Self-organised communities of caregivers function as semi-formal, non-profit actors in job intermediation, as they receive employment offers directly from families seeking care for a relative. In some cases a verbal agreement on the caregiver's rights and responsibilities may be established with the facilitation of the Commission. Moreover, this self-organised community organises regular meetings and community-building events, reinforcing a sense of solidarity and shared struggle among migrant women, as one Commission member told us:

> We sit down, we talk, and I give advice. I [member of commission] say: I know that work is important to you, but don't show that you'll accept anything without limits. Cleaning, laundry, cooking for the whole family—you're going in as a caregiver first of all….So we try to advise from the very beginning, because I say…to all of them: We can't guarantee protection, but we can teach you how to protect yourself. But you also need to know how to communicate in a human way. I'll show you how to draft a contract, how to talk to employers. I explained it all literally. Even little role-plays: "Good morning, good morning," we practiced dialogues like in a theatre setting, so they could learn how to respond to questions from an employer, what kind of questions a worker can ask. (member of the Commission_12)

Another important organisation of this kind is the Caregivers' Alternative Union (Związkowa Alternatywa Opiekunek), which is a part of Związkowa Alternatywa trade union and was established in 2020. This organisation primarily sees its role in improving working conditions in the sector for Polish care workers in Germany through lobbying of the Polish and German governments and public relations, raising awareness about the lack of regulation and poor working conditions in the sector. However, as mentioned by a member of this organisation, Caregivers' Alternative Union has also intervened in many conflict situations between companies, clients, and care workers, and it is involved, more or less directly, in job placement processes through everyday work on social media—for example, maintaining "blacklists" for care workers. Since the work is only partially institutionally supported and financed, and most of it consists of unregulated voluntary activities, this actor should be classified as a semi-formal organisation.

Despite the emergence of inspiring initiatives such as the Caregivers' March (on April 13, 2025, Ukrainian caregivers from the Commission for Domestic Workers marched through the streets of Warsaw to demand better working conditions and legal recognition of their work) and other grassroots union efforts, it is important to recognise that these forms of mobilisation remain limited. Many caregivers continue to work under informal arrangements and lack basic legal protections, which significantly discourages open advocacy. Fear of losing one's employment, migration-related insecurities, and an isolated workplace with long working hours and a general lack of institutional support contribute to the reluctance of many women to engage in public actions or openly demand their rights.

5.5. Agencies and Other Business Entities: Formal For-Profit Actors

Formal for-profit brokering agencies constitute one of the most institutionalised segments of labour intermediation in the care sector and are driven by clear profit expectations linked to demographic ageing: "A commercial enterprise is about making a profit—and senior care is one of those areas where, looking at demographic trends, there's a clear opportunity" (representative of agency_1). However, such agencies remain very heterogeneous, ranging from small regional operators to large corporations with transnational infrastructures. Polish-based agencies often operate in dual markets, simultaneously posting Polish and Ukrainian workers to Germany and other EU countries while recruiting Ukrainians and other non-EU nationals for the Polish care sector. Although the domestic care market in Poland is still relatively small, it has grown steadily, with agencies increasingly adopting business models developed in the Poland–Germany context, including structured recruitment procedures and standardised training. Recruitment strategies typically combine in-house human resources departments with cooperation with independent recruiters under various business-to-business arrangements, allowing agencies to reduce operational risks while maintaining access to migrant networks across sending and receiving countries. External recruiters may be

based in Poland, Ukraine, or elsewhere and operate under diverse legal forms, reflecting the flexible and hybrid character of formal care brokerage, as illustrated by the following statement from a representative of one such agency:

> I have my own human resources department. It currently consists of four people. They're all based in our office. From which we handle recruitment [Ukrainians] both in Poland and in Ukraine. Besides that, we have our own private recruiters—they're more like freelancers—with whom we have B2B contracts for recruitment….Right now, I have people who are based in Poland—and because they have strong networks of contacts in Ukraine, it's worth it for them to open a business in Poland and carry out recruitment activities from here….But I also have people from Ukraine who work for us and are self-employed. (representative of agency_1)

Beyond their recruitment infrastructures, agencies are also engaging in processes of institutionalisation within the Polish market. This includes the emergence of professional associations, industry lobby groups, and collaboration with think tanks that advocate for agency interests in both Poland and Germany. These structures not only facilitate networking and information exchange but also contribute to shaping the regulatory agenda in ways favourable to commercial actors.

While the domestic market continues to expand, agency strategies are increasingly shaped by developments in Germany, which remains the primary destination for many recruits. Regulatory gaps have allowed agencies to operate flexibly; however, anticipated legal reforms—particularly in live-in care—have prompted some to diversify into tightly regulated home nursing services offering hourly care, which are financially compensated within the German healthcare system. This recent shift illustrates how agencies operating in an unregulated field are adapting their business models to secure their position in a potentially more regulated environment.

Despite their organisational sophistication, formal for-profit agencies do not eliminate precarity and exploitation. Caregivers are typically employed under civil law contracts that offer limited protections, while fee distribution lacks transparency and compliance with social insurance obligations remains inconsistent. Although agencies invest in onboarding and basic training, key aspects of working conditions, including rest periods and labour rights, are often left to informal arrangements between caregivers and households.

Recent policy debates in Poland highlight tensions between improving labour standards and maintaining sector viability. In 2024, a proposal to mandate standard employment contracts for migrant caregivers aimed to reduce abuse and informality but faced strong opposition from agencies citing higher costs and administrative burdens. Industry representatives warned that without parallel public funding or enhanced care allowances, such regulation could undermine the affordability and availability of care services.

5.6. Civil Society and Public Institutions: Formal Non-Profit Actors

While various forms of labour intermediation exist in the care sector, none simultaneously guarantee both formal employment and protection from exploitation of migrant workers. As one of our interviewees aptly stated: "The employer wants to save, and the agency wants to profit. And it's always the poor caregivers who suffer. That's also unfair" (Facebook care workers group coordinator_2). Against this backdrop, civil society and public institutions have begun to experiment with what might seem almost impossible in this sector:

formal, non-profit job brokerage. Such initiatives remain rare, but they demonstrate that alternative models are possible.

A key example is provided by church-based organisations such as Caritas and Diakonie, which operate as formal, non-profit, and publicly co-funded and regulated trans-European providers. These actors represent a model approach in terms of fair employment conditions and preventing brain drain effects in sending regions by offering regulated, socially responsible recruitment pathways. The unique feature of live-in care brokerage by non-profit church organisations, such as the Caritas project CariFair, is that they offer a traditional employment contract, which offers several advantages for caregivers compared to the posting model or self-employment model preferred by commercial agencies, including full social rights and transparency regarding their social security contributions and earnings. However, these arrangements have their limitations, particularly when it comes to exercising oversight over private households. This structural constraint highlights the persistent challenges facing even the most ethically driven non-profit brokers. The employer model practiced by Caritas is often not attractive for many families, because it involves higher costs and greater responsibility for the families as employers, even though Caritas takes over the paperwork. As the representative of CariFair explained: "You can't make a lot of money with it. There is a fixed gross contract, everything has to be paid, the families pay a lot, then you have to pay for the support of coordinators." CariFair therefore stressed that political support, for example through subsidies, is needed because the employer model is very expensive for families and currently not competitive in the live-in market.

6. Concluding Discussion

The proposed typology of transnational care-work brokerage aligns with recent research on the growing marketisation of home-care mobility. It shows how the degree of formalisation of commercial brokerage and the resulting business models, which often rely on non-standard employment, reflect brokers' responses to their institutional environment in sending and receiving countries, including care, migration, and labour regimes, as well as supranational and global labour and education markets. These patterns are also shaped by relations with other actors, such as clients, workers, and competitors. By examining processes of informalisation, the typology highlights their preconditions and ambivalent effects on work arrangements and conditions, thereby contributing to ongoing debates on how this kind of care work should be regulated.

Furthermore, the typology offers new insights into the ongoing debate about the commodification and decommodification of care provision, and the respective roles of the market, community, state, and family. It clearly demonstrates the continuing importance of informal brokerage, despite the strong tendency towards formalisation. The persistence of the grey market is due to factors such as labour costs, bureaucratic hurdles for all involved, and a lack of recognition of qualifications. Digitisation and the ability to recruit via social media and job platforms from one's desk and from/to any location have further fuelled informal brokerage. However, it is particularly interesting to note the blurred boundaries between formality and informality, which are becoming evident in various and changing practices and roles of almost all types. These blurred boundaries are part of many business practices of formal organisations, such as agencies that engage in formalised informality. Moreover, informality is widely embraced not only by economic actors but also by non-profit brokers. The sustained relevance and the emergence of new forms of informality are key findings of our typology.

On the one hand, platform-based brokerage introduces regulations such as registration and rating systems into their business models and operates within the formal economy. However, their operations are usually limited to matching and tend to shift working relationships towards undocumented or, at best, non-standard employment. The platforms analysed here are even less formalised than major companies in the field, such as Helpling and care.com. Most platforms are organised as closed groups on social media, primarily Facebook. The practices of their administrators are extremely opaque and correspond much more closely to informal than to formal working relationships. As responsibilities are unclear, there is no quality assurance, monitoring, or evaluation of recruitment and job placements.

On the other hand, we observe a democratising effect of social media, which serve as central transnational infrastructures for care workers. They not only facilitate informal for-profit and non-profit networks but also provide a real boost to grassroots activism and self-organised communities in this challenging field, characterised by professional isolation. Various forms of de-commodification-based solidarity, reciprocity, and exchange develop in informal networks, and these can become successful grassroots organisations that are increasingly institutionalised and supported by established trade unions. However, the organisations we have analysed still primarily rely on the voluntary work of their members. In an unregulated environment, their role remains crucial in combating persistent structures of inequality.

Increased formalisation is particularly evident in commercial agencies engaged in brokerage. Agencies pursue a range of business models, from small self-employed individuals to large corporations and joint stock companies, franchise systems, B2B arrangements, and platforms. These models align with the general trend towards non-standard employment. Companies posting workers to Germany base their employment models primarily on civil law contracts (which are common in the Polish labour market), while in Poland, B2B contracts dominate, particularly for Ukrainian workers who are based in both Poland and Ukraine. In Germany, the self-employment model is becoming more popular.

These national patterns are shaped by EU law. Poland has become a hub for the mobile care sector, largely thanks to the combination of Polish civil law contracts and EU regulations on posting workers within the EU and from third countries. Furthermore, transnational labour markets drive subcontracting cooperation across national borders. Here, non-standard work emerges both from the nature of transnational live-in employment (workers' rotation, domestic work, the relevance of brokerage) and international outwork, in which various actors exploit these arrangements across transnational value chains, pushing responsibility and risk downward (Palenga-Möllenbeck, 2024b). To an increasing extent, this takes the form of formalised precarity: a race to the bottom in white gloves, as formalisation often serves to legitimise precarity.

Through the marketisation of health sectors and explicit or implicit familialisation policies, the state relinquishes its responsibilities to the market, families delegate their responsibilities as employers to agencies, and, ultimately, much responsibility is transferred to care workers, who, in all employment models, are contractors. The intermediary's role is thus crucial: Their choices regarding employment models, their cooperation practices, and their understanding of their role all have a direct impact on the working conditions of care workers.

At the same time, formalising care work remains essential to ensure contracts are precise and transparent, and to provide clear information about job offers and working conditions, genuine support, fair wages, and

free time. Nevertheless, formalisation has significant limits. Caregivers, families, and agencies frequently emphasise the ethos of giving, receiving, and providing care at home, contrasting this with the impersonal character of overly standardised institutional care. In this sense, standardisation is only possible to a certain extent (regarding work processes, professionalisation, and training; see also Fiebig-Spindler, 2026). Nevertheless, non-standard employment models have serious implications for working conditions. Unequal bargaining power, informal negotiation of duties and hours, the influence of stereotypes, and moral frameworks can result in highly ambivalent outcomes. Hence, the broker's role is key here, to manage conflicting expectations such as that of families that often desire "24-hour remote control," as one Polish agency described it. Examples such as the non-profit CariFair and some commercial agencies demonstrate how flexibility and security can be combined.

The proposed typology of brokers holds the potential to be applied in other parts of Europe; its elements can be found in other articles in this thematic issue. We identify comparable patterns globally (Peng, 2024) and in other sectors: The key role of temporary agencies and brokers in enhancing labour market flexibility (Coe et al., 2007) persists, effectively leveraging transnational subcontracting structures and value chains to manage mobility, rotations and housing—as already seen in the meat industry (Mense-Petermann, 2018), construction sector, and agriculture (Palenga-Möllenbeck, 2014). The rise of these transnationally brokered, atypical employment relationships and business models calls for further research and regulation of such transnational labour, including platform-based activities, as well as innovative worker representation through trade unions and independent advisory bodies for these diverse, mobile workforces who increasingly operate on platforms, as self-employed workers, or as franchisees.

At the same time, the typology shows that clear categorisations of roles, rights, and obligations are difficult to define in this specific working environment. Here, agencies take on the tasks of trade unions, trade unions broker jobs, workers become customers of agencies, and families become employers; commercial practices go hand in hand with voluntary work and solidarity. And last but not least: Professional care work itself remains a mixture of informal closeness and formalised distance.

However, brokers remain key actors in shaping transnational home care, not only in terms of the organisation of work but also regarding daily work practices, roles, and responsibilities. In light of the fundamental challenge of reconciling the need for flexible care work with secure working conditions amid gender and racial inequalities, an open process of mediation and negotiation involving all stakeholders and cooperating in stable "working alliances"—community organisations, trade unions, employer associations—is required to develop ethical, fair, and sustainable working models.

Acknowledgments

This research would not have been possible without the cooperation of our partners in the fieldwork, whom we would like to thank. We would also like to thank Ronja Link and Gerard Holden, as well as the anonymous reviewers, for their contributions, which significantly improved the quality of this article. Finally, we would like to express our gratitude to the editors of this thematic issue for this opportunity and for their invaluable feedback and support. This article builds on two collaborative projects. The first project, "Decent Care Work? Transnational Care Arrangements" (2017–2021), was supported by DFG, FWF, and SNF. The second project, "Researching the Transnational Organisation of Senior Care, Labour and Mobility in Central and Eastern Europe (CareOrg)" (2023–2026), is funded by the Volkswagen Foundation.

Funding

Funding from the CareOrg project (Volkswagen Foundation) was used for this research. Publication of this article in open access was made possible through the institutional membership agreement between Goethe University Frankfurt and Cogitatio Press.

Conflict of Interests

The authors declare no conflict of interest.

Data Availability

The data are confidential and largely concern vulnerable groups; therefore, only selected and anonymized datasets are available upon request.

LLMs Disclosure

Perplexity AI was used for formatting the references.

References

Ambrosini, M. (2017). Why irregular migrants arrive and remain: The role of intermediaries. *Journal of Ethnic and Migration Studies*, *43*(11), 1813–1830. https://doi.org/10.1080/1369183X.2016.1260442

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Bastide, L., & Yeoh, B. (2025). Mapping the "middle-spaces" of migration: Towards a linked ecology approach to migration industry, migration infrastructure, and migration brokerage. *Migration Studies*, *13*(1), Article mnaf005. https://doi.org/10.1093/migration/mnaf005

Becker-Schmidt, R. (2004). Doppelte Vergesellschaftung von Frauen: Divergenzen und Brückenschläge zwischen Privat- und Erwerbsleben. In R. Becker & B. Kortendiek (Eds.), *Handbuch Frauen- und Geschlechterforschung* (pp. 53–59). VS Verlag für Sozialwissenschaften.

Bruzelius, C., & Shutes, I. (2022). Towards an understanding of mobility in social policy research. *Global Social Policy*, *22*(3), 503–520. https://doi.org/10.1177/14680181221085477

Chen, M. A. (2015). Informal employment. In S. Edgell, H. Gottfried, & E. Granter (Eds.), *Sage handbook of the sociology of work and employment* (pp. 407–427). Sage.

Coe, N. M., Johns, J., & Ward, K. (2007). Mapping the globalization of the temporary staffing industry. *The Professional Geographer*, *59*(4), 503–520. https://doi.org/10.1111/j.1467-9272.2007.00638.x

Dowling, E. (2021). *The care crisis: What caused it and how can we end it?* Verso.

Esping-Andersen, G. (1990). *The three worlds of welfare capitalism.* Princeton University Press.

Evans, P., & Tilly, C. (2015). The future of work: Escaping the current dystopian trajectory and building better alternatives. In S. Edgell, H. Gottfried, & E. Granter (Eds.), *Sage handbook of the sociology of work and employment* (pp. 651–671). Sage.

Ezzeddine, P. (2024). Care bonds in times of COVID-19. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 135–152). Sage.

Faist, T. (2014). Brokerage in cross-border migration: From networks to social mechanisms (COMCAD Working Paper No. 121). COMCAD. https://tinyurl.com/2f43vkxf

Farris, S. R., & Marchetti, S. (2017). From the commodification to the corporatization of care: European perspectives and debates. *Social Politics: International Studies in Gender, State & Society*, *24*(2), 109–131.

Fedyuk, O., Kyliushyk, I., & Lashchuk, I. (2023). *New (im)possibilities for agriculture and domestic services in Poland and Italy? Navigating legal solutions and social organisations support for Ukrainian women displaced by the full-scale invasion of Ukraine in 2022* (Working Paper No. 134/192). Centre of Migration Research (CMR), University of Warsaw.

Fiebig-Spindler, R. (2026). Selling care skills? The multiple meanings of training for Polish live-in care workers in Germany. *Social Inclusion*, *14*, Article 11909. https://doi.org/10.17645/si.11909

Folbre, N. (2001). *The invisible heart: Economics and family values*. New Press.

Fraser, N. (2022). *Cannibal capitalism: How our system is devouring democracy, care and the planet—and what we can do about it*. Verso.

Fudge, J., & Hobden, C. (2018). *Conceptualizing the role of intermediaries in formalizing domestic work*. ILO.

Kałuża-Kopias, D. (2018). Imigranci w systemie opieki nad osobami starszymi. *Rynek Pracy*, *3*(166), 36–45.

Kindler, M. (2008). *Risk and risk strategies of labour migrants: The case of Ukrainian domestic workers in Poland* [Unpublished PhD thesis]. European University Viadrina. https://library.oapen.org/bitstream/handle/20.500.12657/34536/416051.pdf?sequence=1

Kindler, M., & Szulecka, M. (2022). Messy arrangements? A social networks perspective on migrant labor brokerage: The case of Ukrainian migration to Poland. *Polish Sociological Review*, *220*(4), 403–421. https://doi.org/10.26412/psr220.03

Klakla, J. B., Koss-Goryszewska, M., Kulesa, A., Pająk-Załęska, K., & Zarychta, M. (2023). *In the shadows: Ukrainian domestic workers in Poland*. Care International Poland.

Koster, M. (2019). *Assembling formal and informal urban governance: Political brokerage in Recife, Brazil*. *Anthropologica*, *61*(1), 25–34.

Kyliushyk, I., & Chról, E. (2025). Ukrainian female migration in a historical perspective. In I. Grabowska, I. Kyliushyk, & E. Chról (Eds.), *Ukrainian female war migrants: Mobilising resources for prospective social remittances?* (pp. 7–30). Routledge.

Leiber, S., Rossow, V., & Matuszczyk, K. (2019). Migrant care work and the role of intermediaries in cross-border labour markets: A classification of brokerage in Polish-German senior care. *Social Policy & Administration*, *53*(6), 952–967. https://doi.org/10.1111/spol.12531

Lessenich, S. (2016). *Neben uns die Sintflut: Die Externalisierungsgesellschaft und ihr Preis*. Carl Hanser.

Lewicki, A., & Probst, U. (2026). Sex, care and the working body: Ambiguities of the gendered racialisation as 'Eastern European.' *Journal of Ethnic and Migration Studies*, 52(1), 41–64. https://doi.org/10.1080/1369183X.2025.2462779

Lutz, H. (2025). *The backstage of the care economy: Transnational perspectives on the commercialisation of care*. Pluto Press.

Lutz, H., & Palenga-Möllenbeck, E. (2011). Care, gender and migration: Towards a theory of transnational domestic work migration in Europe. *Journal of Contemporary European Studies*, *19*(3), 349–364. https://doi.org/10.1080/14782804.2011.610605

Matuszczyk, K., & Kowalska, K. (2024). Are labour markets inclusive for Ukrainian war migrants? Perspectives From Polish and Italian migration infrastructure actors. *Social Inclusion*, *12*, Article 8798. https://doi.org/10.17645/si.8798

Mense-Petermann, U. (2018). *Transnationale Arbeitsmobilität und Werkverträge in der Fleischindustrie*. In U. Mense-Petermann & M. Wagner (Eds.), *Transnationale Arbeit in Europa: Strukturen, Praktiken und Regulierung* (pp. 23–31). Springer.

Müller, T., & Skeide, A. (2026). Grounded Theory und Biographieforschung. In M. Schiebel, E. Tuider, & H. Lutz (Eds.), *Handbuch Biographieforschung* (pp. 1–12). Springer. https://doi.org/10.1007/978-3-658-49799-6_5-1

Palenga-Möllenbeck, E. (2014). *Pendelmigration aus Oberschlesien: Lebensgeschichten in einer transnationalen Region Europas*. transcript.

Palenga-Möllenbeck, E. (2024a). Sozialtourismus in Deutschland? Wie reproduktive Arbeit unsichtbar wird. In M. Menz, D. Rellstab, & M. Stock (Eds.), *Körper und Emotionen in Bewegung: Migrationsgesellschaftliche Perspektiven auf Bildung, Politik und Familie* (pp. 145–169). Springer.

Palenga-Möllenbeck, E. (2024b). Divided Europe? The role of home care agencies from Poland, and how the ideal of decent work gets lost along transnational value chains. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 23–36). Sage.

Peng, I. (2024). *Migrant care work and the marketization of eldercare: Intermediaries in comparative perspective*. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Rogalewski, A., & Florek, K. (2020). *The future of live-in care work in Europe: Report on the EESC country visits to the United Kingdom, Germany, Italy and Poland following up on the EESC opinion on 'The rights of live-in care workers.'* European Economic and Social Committee.

Stan, S., & Erne, R. (2024). Pursuing an overarching commodification script through country-specific interventions? The EU's new economic governance prescriptions in healthcare (2009–2019). *Socio-Economic Review*, *22*(4), 1733–1754. https://doi.org/10.1093/ser/mwad053

Strüver, A. (2021). Care to go: Arbeitsbedingungen und- beziehungen in der plattformvermittelten Sorgearbeit. *Kurswechsel*, *4*, 105–109.

Tronto, J. C. (1989). Women and caring: Or, what can feminists learn from caring? In A. Jaggar & S. Bordo (Eds.), *Gender/body/knowledge: Feminist reconstructions of being and knowing* (pp. 172–187). Rutgers University Press.

Uhde, Z. (2024). Distorted emancipation and the transnational political economy of social reproduction. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwitzer (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 112–126). Sage.

Wetterer, A. (2017). *Arbeitsteilung und Geschlechterkonstruktion: 'Gender at work' in theoretischer und historischer Perspektive*. Herbert von Halem.

Xiang, B., & Lindquist, J. (2014). Migration infrastructure. *International Migration Review*, *48*(1), 122–148. https://doi.org/10.1111/imre.12141

Yeates, N. (2009). *Globalizing care economies and migrant workers: Explorations in global care chains*. Palgrave Macmillan.

About the Authors



Ewa Palenga-Möllenbeck (PhD) is PI and research group leader in the CareOrg project at the Institute of Sociology and the Interdisciplinary Centre for Gender Studies, Goethe University Frankfurt. She is interested in the nexus of migration, work, care, and social inequalities, specialising in issues of ageing and transnational families, welfare/policy analysis, and intersectionality.



Ivanna Kyliushyk (PhD) is a political scientist and sociologist specialising in Ukrainian migration. Her research focuses on migrants' social and labour market integration, mobility capital, transnational practices, and political inclusion. She is a researcher at the Centre for Research on Social Change and Human Mobility (CRASH) at Kozminski University.



Roxana Fiebig-Spindler (MA) is a research assistant in the international CareOrg project at the Institute of Sociology, Goethe University Frankfurt. Since completing her master's thesis in cultural anthropology, she has researched migrant care work, focusing on Polish care workers in Germany. Her research interests include migration, care, and social inequalities.

Social Inclusion
2026 • Volume 14 • Article 11975
https://doi.org/10.17645/si.11975

cogitatio

ARTICLE

Open Access Journal

Care Extractivism Beyond Households: Migration and Care for Older People in the Post-Yugoslav Semi-Periphery

Majda Hrženjak

Peace Institute, Slovenia

Correspondence: Majda Hrženjak (majda.hrzenjak@mirovni-institut.si)

Submitted: 20 January 2026 **Accepted:** 21 April 2026 **Published:** 14 May 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

This article examines care-labour mobility between Slovenia and Bosnia and Herzegovina (BiH) within the state-organised system of residential care for older people, situating it on Europe's semi-periphery. Addressing gaps in European research, largely focused on private households and East–West intra-EU mobility, it shifts attention to welfare states as employers embedded in asymmetric geopolitical relations. Drawing on interviews with migrant care workers and institutional actors in Slovenia and BiH, the analysis conceptualises this mobility through the lens of care extractivism, understood as the structured over-extraction of labour, time, and skills through the interaction of migration regimes, labour market segmentation, and welfare arrangements. The article shows how the interplay between Slovenia's care deficits and BiH's position within postwar state formation and uneven European integration, both shaped by broader political and economic transformations over the past three decades, produces a relational field of labour mobility rooted in the shared post-Yugoslav space. It identifies key mechanisms of extraction, including employer-tied migration regimes, family-based recruitment, dequalification and skill extraction, temporal over-availability, and the externalisation of social reproduction onto migrant networks. The article contributes to existing scholarship by demonstrating how welfare states actively organise transnational care extraction and by advancing care extractivism as a conceptual framework for analysing hierarchical relations across multiple Europes.

Keywords

care extractivism; care for older people; residential care; Eastern Europe; Balkans; postwar context

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Across Europe, systems of care for older people are facing deepening labour shortages. This is driven not only by rapid population ageing, but also by the structural undervaluation of care work, which itself is exacerbated by decades of neoliberal cost containment in social welfare. Many countries have turned to cross-border recruitment as a key strategy, formalizing and informalizing various channels for the inflow of migrant workers (Eurofound, 2020; Widding Isaksen, 2012; Yeates, 2009). The intensification of care migration in Europe since the 1990s has also been driven by profound geopolitical transformations, including political and economic restructuring, shifts in borders and border regimes, EU enlargement, and wars. These processes have produced enduring inequalities between East and West, "old" and "new" EU member states, and core and semi-peripheral regions which structure care-labour mobility (Lutz, 2011; Triandafyllidou & Marchetti, 2013). Numerous studies have demonstrated that this reliance is deeply problematic, as migrant workers are incorporated into local labour markets in disparate ways that reproduce global inequalities and exploitative relationships (Mezzadra & Neilson, 2013; Shutes & Chiatti, 2012). Historically, care work has been organized along entrenched hierarchies of gender, class, race, and the colonial and neo-colonial North-South divide (Nakano Glenn, 1992). In contemporary Europe, these logics persist through the production of a given nation's "other" via migration and labour regimes—top-down regulatory frameworks that determine which groups gain access to specific segments of the labour market (Gutiérrez-Rodríguez, 2010).

European research at the intersection of care, migration, and gender has primarily focused on East-to-West mobility and the employment of live-in care workers in households. In this strand of knowledge production, the relative invisibility of Eastern European countries as *receiving* states for migrant care work stems from a perspective that prioritizes Western European care regimes and positions the region primarily as labour-*sending* periphery. This perspective reinforces a unidirectional understanding of care migration and obscures care deficits within Eastern regions. Since the 1980s, long-term care reforms in Western welfare states have promoted a "third" pillar of care, combining ageing-in-place and cash-for-care policies with the expansion of market-based live-in care arrangements (Lutz, 2011; Ungerson & Yeandle, 2007). Consequently, scholarship on the transnational division of care has largely focused on migrant women from Eastern Europe employed in private households, often under irregular conditions, mediated by agencies, and engaged in circular migration (Aulenbacher et al., 2024). By contrast, care infrastructures in Eastern countries remain heavily reliant on family-based care, with limited formal services and low levels of public investment. Cash-for-care policies and the employment of live-in care workers in households are less prevalent (Katona & Melegh, 2021). Within a research framework that prioritises live-in migrant care work, institutionalized forms of care migration, where welfare states recruit and employ migrant labour within residential care for older people, have therefore received less attention (Cuban, 2013; Sahraoui, 2019; Shutes & Chiatti, 2012; Widding Isaksen, 2012). Examining migrant labour within formal care institutions reveals that the state itself serves as a central producer of differentiated and unequal labour regimes, mobilizing EU and "third-country" migration frameworks to incorporate migrant women into care provision. Although institutional employment is more regulated than private household arrangements, it remains grounded in stratified rights, constrained mobility, and segmented pathways to employment that reproduce migrant workers' subordination and transnational inequalities in care.

This article addresses these research gaps by analysing the transnationalization of care within a state network of residential care for older people on the European semi-periphery, focusing on labour mobility between Slovenia and Bosnia-Herzegovina (BiH), both constituent parts of former Yugoslavia, before the 1990s. This European micro-region, located at the geopolitical crossroads of Eastern and Western Europe, the Balkans, and the EU, carries a post-socialist and postwar legacy shaped by political and economic transition, shifting state borders, and changing border regimes. The article traces how divergent transformation trajectories over the past three decades have differentially positioned Slovenia and BiH within contemporary care-labour mobility, with Slovenia emerging as a site of labour incorporation and BiH as a major source of labour supply within the European integration project. Without denying individual agency, the analysis centres on the geopolitical dimensions of these processes, showing how care-labour mobility unfolds within historically and symbolically structured hierarchies that position the region unevenly within Europe. BiH, in particular, is embedded in a regime of othering that reinforces its peripheralization, while in Slovenia such hierarchies are reproduced through EU-oriented nation-building that constructs "Europe" in opposition to the "Balkan Other" (Lewicki, 2023; Pistotnik & Brown, 2018). Examining care-labour mobility also across Europe's semi-peripheries deepens empirical and conceptual insight into a hierarchical model of multiple "Europes" (Kussy & Moll, 2023), in which care regimes are structured by geopolitical inequalities.

The analysis draws on recent theoretical conceptualisations of care extractivism (Uhde, 2025; Wichterich, 2020), which interrogate the macro-level mechanisms through which welfare states, labour markets, and migration regimes organise the transnational extraction of care. This framework highlights how unequal political and economic relations enable wealthier states to externalise the costs of care, while depleting care capacities elsewhere through recruitment schemes, visa regimes, and labour brokerage. Focusing on the Slovenia and BiH labour mobility nexus, the article conceptualizes care extractivism as a relational process that operates across and through state borders through which transnational regimes of labour, care, and inequality are organized and enacted. It situates Slovenia and BiH within a broader regime of labour extraction shaped by political and economic restructuring, uneven European integration, and the geopolitical settlement of the postwar order. The article begins by introducing the theoretical framework. Following a methodological outline, it examines the divergent trajectories of state transformation in Slovenia and BiH to identify the structural conditions under which care becomes available, mobile, and extractable within transnational labour regimes. It then analyses how these conditions are translated into specific mechanisms of care extractivism, linking the two countries within the residential care sector.

2. The Theoretical Background: Care Extractivism in the Post-Yugoslav Semi-Periphery

Care extractivism refers to a set of structural mechanisms through which care systems secure their reproduction under conditions of chronic underfunding and a widening gap between care needs and available resources. Rather than resolving the structural crisis of care, these mechanisms operate as care fixes (Dowling, 2021), enabling states and labour markets to stabilize care provision while leaving its underlying causes unaddressed. The concept highlights a political-economic logic in which value is continuously extracted from feminized and racialized labour to sustain care regimes. Care extractivism can be understood as part of broader transformations in contemporary capitalism, in which social reproduction is increasingly reorganised under conditions of fiscal constraint, marketisation, and uneven development. Feminist social reproduction theory has long emphasised that capitalism structurally requires low social

reproduction costs through individualisation, privatisation, and feminisation mechanisms (Bhattacharya, 2017; Fraser, 2022). In the semi-periphery, the dependent socioeconomic development makes the urge to contain public spending even more pressing (Bohle & Greskovits, 2012). In this framework, crises of care are structural, emerging from tensions between capital accumulation and the social organisation of reproduction. Care extractivism can thus be seen as a strategy through which these tensions are managed, by displacing the costs of social reproduction onto feminised, racialised, and increasingly migrant labour. This displacement operates across multiple scales, linking welfare-state restructuring, labour market segmentation, and transnational inequalities.

Following Wichterich (2020), care extractivism operates through both domestic and transnational modalities. Domestic extraction unfolds, first, through familialism, whereby states displace responsibility for care onto families, primarily women, under the guise of kinship obligation and moral economies of care. A second form emerges through the commercialization and managerialization of care provision, often accompanied by chronic underinvestment in public infrastructure, intensified workloads, and sustained pressure to contain labour costs. Under such conditions, care systems rely on the systematic extension and intensification of labour beyond contractual limits, producing a surplus of labour extracted from workers. Transnational care extraction, in turn, operates through the cross-border reorganization of labour under conditions of unequal incorporation into labour markets. Drawing on critical migration and border studies, mobility is understood as a process, structured through bordering practices, legal differentiation, and labour market segmentation (Mezzadra & Neilson, 2013). As Uhde (2025) underlines, mobility itself is not inherently extractive; rather, extraction occurs in how mobility is governed and exploited. Migrant women are differentially included in care labour markets through restricted access to employment, which enables the intensification and flexibilization of their labour. These processes are further shaped by racialized and gendered imaginaries that naturalize migrant women's suitability for care work (Wichterich, 2020).

Political and economic restructuring in Eastern Europe has produced differentiated positions within the European political economy, shaping both the availability and valuation of care labour across the region (Bohle & Greskovits, 2012). In Slovenia, processes of capitalist consolidation and EU integration have been accompanied by the restructuring of care for older people through sustained underfunding and privatisation, generating structural labour shortages that are increasingly addressed through the recruitment of migrant women, thereby linking domestic care deficits to transnational labour regimes (Hrženjak, 2025). In BiH, by contrast, political and economic restructuring has unfolded alongside a postwar condition. Rather than an internally generated condition, this arrangement is approached here as a geopolitically produced framework that contributes to the conditions under which labour becomes mobile and available. In this context, BiH occupies a position on the external margins of the European labour market, where liberalised mobility coexists with limited socio-economic opportunities (Henig et al., 2025; Majstorović, 2021). The contemporary organisation of care migration in the region is further shaped by the historical legacy of Yugoslavia, which provides an infrastructural and social basis for mobility. Linguistic, social, and institutional ties facilitate migration patterns that are subsequently reorganised within European labour regimes. This article unfolds care extractivism in the Slovenia–BiH context as a process emerging at the intersection of these historical and geopolitical dynamics, shaping differentiated forms of labour mobility, incorporation, and exploitation.

3. Methodological Notes

Empirical data were collected through a review of policy frameworks and the incidence of labour migration between Slovenia and former Yugoslav countries, as well as three series of interviews conducted within the research project "Transnationalisation of Eldercare: Diversities, Recruitments, Inequalities" (2021–2025, SRIA). In 2023, sixteen interviews were conducted with migrant care workers employed in residential care for older people in Slovenia, all coming from former Yugoslav countries. The inclusion criteria were migration within the past ten years and current employment in the eldercare sector. Of the participants, ten were from BiH, three from Serbia, two from Croatia, and one from North Macedonia. This article focuses on a subsample of ten interviewees from BiH. They were all women, aged between 25 and 55, who had migrated either through family reunification or as independent labour migrants. In terms of educational background, four participants were qualified nurses, one was a physiotherapist, three had completed general secondary education, and two had vocational training. Most participants were recruited through trade union representatives, while some were recruited through the management of residential care facilities. Interviews were conducted in the participants' native language and took place at locations chosen by the interviewees, most commonly in cafés or at their workplaces before or after shifts. To ensure anonymity, participants selected pseudonyms; identifying details such as place of residence and work were omitted. Interviews lasted between 30 and 90 minutes and were audio-recorded and transcribed based on a prior written informed consent. The interviews addressed participants' pre-migration trajectories, motivations for migration, experiences with visa procedures, housing, working conditions, discrimination, transnational aspects of intimate life, and future plans. The material was analysed through close reading of transcripts and coding and categorisation using MAXQDA. Given the exploratory nature of the study, the range of identified themes was broad. This article focuses on a subset of these themes: recruitment processes, dequalification, temporal over-availability, and the privatised integration through migrant networks.

For the collection of contextual information in Slovenia and BiH, two series of problem-centred expert interviews were conducted (Döringer, 2020; Witzel, 2000). Problem-centred expert interview is a qualitative method that combines inductive openness with theoretically guided inquiry. This approach integrates narrative-generating questions with focused follow-up prompts, enabling the reconstruction of participants' problem framings alongside domain-specific insights. These interviews were used to deepen the analysis beyond policy and institutional frameworks by incorporating situated "insider" knowledge from actors embedded within the institutional and social field under study. The inclusion of actors from BiH enabled engagement with an epistemological orientation that values knowledge produced from the margins (Harding, 1992), thereby foregrounding perspectives that are often overlooked in institutional analyses.

In 2022, eleven interviews were carried out in Slovenia with directors of major private and public residential care providers, trade union representatives, a representative of the Association of Social Care Institutions of Slovenia, a migration officer at the Employment Service of Slovenia, and policymakers at the Ministry of Labour, Family, Social Affairs and Equal Opportunities responsible for long-term care. Each interview began with a broad narrative question exploring labour shortages and the role of labour migration in addressing workforce deficits, followed by thematically tailored follow-up prompts adapted to each participant's area of expertise, including working conditions, recruitment and integration strategies, and future policy developments. The interviews lasted between 60 and 120 minutes and were audio-recorded and transcribed. All participants provided written informed consent prior to participation.

For the Sarajevo fieldwork in 2023, participant selection was based on preparatory desk research reviewing national studies on the socio-economic and political context of BiH. This enabled the identification of experts operating at the intersection of migration, care, labour, and gender regimes. Interviews were carried out with the following interlocutors: a social policy expert from the Faculty of Political Sciences and a migration scholar from the Faculty of Economics, both at the University of Sarajevo; the director of a state residential care home; the president of the Trade Union of Retail and Service Workers; the coordinator of the "Triple Win" programme at the Agency for Labour and Employment, which regulates the labour migration of nurses to Germany; a representative of a private labour recruitment agency; the director of the Fami Foundation working on strengthening the nursing profession in BiH; and a representative of Crvena, an NGO engaged in gender equality. Participants were contacted and invited to participate via email. Each interview began with a broad narrative question on the migration situation in BiH, followed by targeted prompts addressing migration governance, labour market dynamics, care provision, and gender relations. Interviews were carried out in the Bosnian language by two researchers, including the author. They lasted between 90 and 120 minutes and were audio-recorded and transcribed. Prior to participation, all interlocutors provided written informed consent. Given the heterogeneity of both series of expert interviews, the analysis did not aim at systematic comparison across expert accounts. Instead, interviews were used to generate domain-specific insights into the Slovenian and BiH context. They functioned as a contextual and interpretive layer, complementing other data and enabling a more nuanced understanding of the care migration between Slovenia and BiH.

4. Labour Mobility and Post-Yugoslav Transformation in Slovenia and BiH

Transformations following the dissolution of socialism in the former Yugoslav space have produced differentiated trajectories of state restructuring and uneven incorporation into the European political economy, ranging from Slovenia's early EU integration to BiH's postwar fragmentation. These trajectories are embedded in geopolitical arrangements that actively structure labour mobility (Bohle & Greskovits, 2012).

4.1. Slovenia: Catching Up With Europe

Slovenia followed a comparatively moderate transformation path in the 1990s, combining gradual privatization, macroeconomic stabilization, and the preservation of social dialogue. Its welfare system developed into a "continental mixed" model (Kolarič et al., 2011, p. 290). However, EU accession in 2004, followed by the 2008 economic crisis and subsequent austerity measures, intensified neoliberal pressures towards privatization, fiscal consolidation, and labour-market deregulation. Framed through the discourse of "catching up with Europe" (Blagojević, 2013; Samaluk, 2016), Slovenia increasingly prioritised fiscal discipline, competitiveness, and market efficiency over social investment. Within this framework, social welfare, particularly care for a rapidly ageing population, came to function as a buffer for fiscal constraints (Mandič, 2016). Care for older people has consequently undergone a neoliberal restructuring marked by the expansion of public–private partnerships, and cost-shifting to users. Residential care, organised as a unified network of public and private providers under state regulation, has been strained by chronic underfunding and stagnant staffing standards despite rising care needs (Hrženjak, 2025). Experts in our interviews consistently identified poor working conditions and low wages as key drivers of labour shortages. Unchanged staff-to-user ratios over three decades have intensified labour and reduced care quality, particularly with the growing share of highly dependent residents. Care home managers reported persistent

vacancies forcing remaining staff to absorb workloads through overtime, while trade unionists described care workers as working "nonstop," being worn out, and accumulating unpaid hours they are unable to take as time off. These pressures are reflected in Slovenia's exceptionally low staffing ratio of 1.8 care workers per 100 people aged 65 and over, compared to an OECD average of 5.0 (OECD, 2025), indicating a high degree of work intensification. Despite the introduction of a minimum wage in 1995, front-line care workers remained below this threshold until the 2024 wage reform, leaving many exposed to in-work poverty despite demanding shift work (Hrženjak, 2025).

These deteriorating working conditions constitute a form of domestic care extraction that simultaneously generates the structural demand for transnational labour, linking internal welfare restructuring to broader extractive care regimes. Care workers increasingly leave the sector for better-paid employment in manufacturing and retail or migrate to Austria and Italy, where home-based care is supported through cash-for-care schemes (Hrženjak & Breznik, 2024a). In 2023, after three decades of postponement, Slovenia adopted a long-term care reform, consolidating the state network of service provision and introducing long-term care insurance designed to improve financial sustainability. While these measures constituted necessary steps towards system consolidation, acute labour shortages have posed a serious threat to effective implementation. Rather than addressing the structural undervaluation and intensification of care work, the government has largely continued cost-containment strategies and has increasingly turned to the recruitment of migrant women. A representative of the Ministry of Labor, Family, Social Affairs and Equal Opportunities in our interview says:

> There are measures to facilitate the employment of foreigners. But the Balkan pool is already emptying. We think there may still be a reserve in Kosovo, Albania, Romania, maybe the Philippines. We absolutely welcome anything that would make it easier to attract workers from other countries.

The restructuring of Slovenia's care system thus actively produces the conditions under which care provision becomes dependent on extractive forms of migrant labour. Official statistics show that the share of migrant women in residential care increased from 0.5 percent in 2007 to 7.8 percent in 2023. A clear majority, around 60 percent, are citizens of BiH, with the remainder coming primarily from Serbia, North Macedonia, and Croatia (Hrženjak & Breznik, 2024b).

4.2. BiH: Postwar and Socioeconomic Transformation and the Production of Labour Mobility

BiH exhibits structurally distinctive characteristics, having entered its political and economic transition in a war-torn condition marked by fragmented statehood and extensive human and infrastructural losses. Post-conflict scholarship has cautioned against imagining a sharp rupture between "war" and "peace" (Black & Gent, 2006). The 1995 Dayton Peace Agreement, brokered under strong international mediation led by the United States and supported by the EU, ended the war in BiH but established a complex power-sharing system based on ethnic representation. It divided the country into two entities and one district and introduced multiple layers of governance with veto powers for the three constituent groups. While securing peace, this arrangement entrenched ethnic divisions and produced a fragmented state structure marked by political deadlock and limited institutional capacity (Belloni, 2009; Bose, 2002; Pašić, 2024). These dynamics unfolded alongside economic restructuring typical of the region, which, as some authors argue, affected livelihoods on a scale comparable to the war itself (Henig et al., 2025, p. 6). War-related destruction, rapid

and often opaque privatization, and BiH's protracted integration into the EU have produced a postwar economy characterized by persistent unemployment, precarious work, and widespread informalization (Domazet et al., 2020). Everyday governance is marked by what Jansen (2015) described as a "meanwhile temporality"—an in-between temporal and spatial condition that is neither fully war nor fully postwar, but rather a state of living permanently in the meantime.

In this context of structural volatility, migration emerges as an individualized form of agency that has normalized the idea of emigration as an ordinary component of livelihood repertoires (Majstorović, 2021, p. 197). Despite limited official statistics, estimates suggest that the diaspora now accounts for more than half of BiH's current population (Domazet et al., 2020, p. 189; Efendić, 2021; Jahić et al., 2024; Jakovljević et al., 2021, p. 15). Our expert interviews point to two emerging patterns that replace earlier forms of male-dominated *Gasterbeiter* migration and wartime refugee exit. The first is characterised by the permanent, intergenerational exit of entire households. As one expert from the Faculty of Economics noted:

> It is not only the unemployed who migrate, but also those who are employed; in fact, entire families leave, and many of them are well-off. Workers with good salaries, these are the people who go. Families with highly educated members are acutely aware that without political stability, there can be no economic prosperity. They leave good jobs here in pursuit of a better overall quality of life. They move for security, for the future, for their children, for better education, better healthcare, and a more reliable institutional environment.

This account highlights a shift towards migration as a long-term strategy of social reproduction, driven not only by economic necessity but by the search for institutional stability and future-oriented life chances. In contrast, a second pattern is marked by fragmented, cyclical, and often informal mobility. As described by a trade union representative:

> What I see as the real problem is that most of the people who leave are young. Many of them go for just three months, entering EU countries on tourist visas and working off the books. They might spend three months abroad and then six months back in BiH, and so on. These young people simply cannot plan their future. I think a new group of people is emerging, people who are literally nowhere, caught neither here nor there. They grow older because this in-between period keeps dragging on endlessly.

The Dayton Accord, in intersection with processes of political and economic restructuring and uneven EU integration, thus constitutes a geopolitically produced set of structural conditions under which labour becomes available, mobile, and ultimately extractable within transnational labour regimes. The normalization of mobility feeds back into BiH, generating cumulative political-economic effects. As noted by a representative of the Fami Foundation, "the state is losing vital social, labour, and reproductive capital." Our interlocutor in trade union suggested that, in recent years, BiH has significantly reduced unemployment while simultaneously experiencing growing skills shortages and labour mismatches in specific sectors. In response, employers have increasingly begun recruiting workers from South and Southeast Asia. The private recruitment agency included in our study has already adapted to these dynamics by facilitating labour migration from Nepal, India, Pakistan, and Uzbekistan.

Emigration has also profoundly reshaped the care sector, revealing how care systems are actively produced through ongoing labour outflows. Despite a formal surplus of medically trained workers (Jahić et al., 2024; Schmitz-Pranghe et al., 2020), domestic care and health systems remain underdeveloped and underfunded, shaped by strong familial care norms (Hromadžić, 2016; Obradović & Jusić, 2021; UN Women, 2023). At the same time, young people increasingly view nursing education not as a pathway into domestic employment, but as a strategic route to emigration (Jahić et al., 2024; Šeherčehajić & Ramić, 2022). This orientation has prompted steadily rising enrolments in nursing programmes offered by five public and four private secondary schools—an expanding business niche closely tied to emigration prospects (Jahić et al., 2024, p. 14). This dynamic is closely linked to institutionalised migration pathways, most notably the "Triple Win" programme between BiH and Germany, which facilitates the recruitment of qualified nurses into the German healthcare system. As noted by our interviewee from the Fami Foundation, some educational institutions are actively aligning their curricula with Western, particularly German, standards to improve graduates' employability abroad. Though occupational profiles in residential care range from skilled professionals, such as nurses, to lower-skilled care and service workers, our interviews indicate that in Slovenia, too, care homes prioritise trained nurses, who are recruited into lower-skilled positions and required to undergo language, recognition, and certification procedures before accessing qualified positions. In this context, nursing education becomes directly embedded in transnational labour recruitment infrastructures, producing a workforce that is formally trained for export. In line with Yeates' (2009) conceptualisation of education as part of a migrant labour commodity chain, training systems thus operate as infrastructures that produce mobile and "job-ready" labour for external markets, while simultaneously contributing to the erosion of domestic care and health capacities (Breznik et al., 2025). As the Fami Foundation representative explained in our interviews: "We are entering a situation where nurses are missing from our healthcare system. You do not feel this as strongly in major centres like Sarajevo, but it is already visible in peripheral areas."

Our interlocutor from the Faculty of Political Science noted that emigration is profoundly reshaping local care arrangements and generating new care gaps. In a context of strong familialisation of care for older people, responsibility is primarily borne by adult children; their outmigration disrupts these arrangements, producing unmet needs. As a result, demand for residential care has increased, yet this demand is being met predominantly by market providers rather than public facilities. This dynamic has given rise to an emigration-driven care economy, in which care deficits generated by migration are converted into profitable market opportunities. As a representative of the Fami Foundation observed, "private care homes are mushrooming; it is a highly lucrative business." In the context of expanding market-based provision, remittances not only sustain everyday life, particularly for older people facing low or absent pensions (Jakovljević et al., 2021; Pranjić & Račić, 2020) but are increasingly mobilised to finance the high costs of residential care in private facilities. Transnational family transfers thus become directly implicated in the commodification of care, effectively subsidising a privatised sector that has emerged in response to emigration-induced care gaps. At the same time, remittances contribute to the stabilisation of existing socio-economic arrangements by alleviating pressures for structural reform. As noted by an expert from the Faculty of Political Science: "These millions, almost 30 percent of our GDP, maintain social peace; they sustain the status quo." Taken together, these dynamics reveal a self-reinforcing feedback loop in which emigration not only responds to structural constraints but also contributes to their reproduction. In this way, the conditions that drive emigration are continuously regenerated through its own effects, contributing to the sustained availability and circulation of labour across borders. The following section examines how these structurally produced conditions of mobility are operationalised through concrete extractive mechanisms

within care labour migration, using the BiH and Slovenia care migration nexus as a strategically situated lens into the broader reorganisation of care, labour, and mobility across Europe.

5. Mechanisms of Care Extractivism Between BiH and Slovenia

Here, care extractivism is understood not as reducible to labour migration itself, but as the structured over-extraction of labour, time, skills, and affect through the interaction of migration regimes, labour market segmentation, and welfare state arrangements. Extraction is actively institutionalised through legal and policy frameworks that function as bordering practices, differentially incorporating migrant women into care labour (Mezzadra & Neilson, 2013; Uhde, 2025). Building on this understanding, this section identifies key mechanisms through which migrant women's labour is incorporated, controlled, and intensified within residential care for older people. These mechanisms form an interconnected regime that stabilises care provision through the extraction of labour, time, skills, and social reproductive capacities.

Migration regimes between BiH and Slovenia have undergone significant transformation since Slovenia's accession to the Schengen Area in 2007. While internal EU mobility was liberalised, migration from non-EU countries became increasingly regulated. Following the post-2008 slowdown, labour migration from BiH intensified from 2017 onwards, as Slovenia faced acute labour shortages driven by demographic ageing and economic growth (Jakovljević et al., 2021). Workers from BiH now constitute the largest group of foreign labour in Slovenia, accounting for a substantial share of work permits, often exceeding half of newly issued permits, and numbering approximately 50,000 to 70,000 workers, indicating that BiH functions as a key reservoir of labour for the Slovenian economy (Bajt et al., 2025).

Our analysis identifies several extractive mechanisms, some general to migrant labour and others specific to the care sector. One central mechanism is embedded in the 2012 bilateral agreement between Slovenia and BiH, which regulates labour migration under the stated goals of "balanced migration flows" and the "positive effects of circular migration" (Oruč & Kurta, 2024). While the agreement provides a legal pathway to employment and residency, it simultaneously establishes employer-tied work permits, requiring migrant workers to remain with the initial employer during the first year of employment. This arrangement functions as a bordering mechanism that restricts labour market mobility and produces a condition of differential inclusion, incorporating workers under conditions of dependency and constrained autonomy. In the care sector, as in others, this enables the intensification of labour, the acceptance of unfavourable working conditions, and the extension of working time, thereby facilitating the extraction of surplus labour. As noted by Breznik (2024), the requirement is also discriminatory, as EU, EEA, and Swiss nationals face no such restrictions.

A second, distinctly gendered mechanism, characteristic of the care sector, operates through the intersection of bilateral labour agreements and family reunification. While women also migrate independently, family reunification remains the dominant pathway (Jakovljević et al., 2021). Care providers actively mobilise migrant workers' social networks to recruit additional labour. As a manager of a public residential facility in Slovenia explained in our interview:

> We have used the social capital we have because we already have many employees from BiH. They still go to their hometowns and have contacts there. They bring their relatives, their neighbours, their

> informal network. That has paid off the most for us. At the staff meeting and in the home's newsletter, the director addressed the employees, saying that we are in a difficult situation and would like to ask if anyone [knew] anyone who would like to come and work for us to please bring them.

Similarly, private providers cooperate with sectors employing migrant men to recruit female family members:

> We are looking for those already living in Slovenia who have a residence permit based on family reunification because the husband is already here. Then it is much easier. Then we just have to fill in an information sheet.

Although formally framed as a social right, family reunification operates as a bordering mechanism that restricts labour market access. In principle, employment is conditional on labour market verification; however, in the care sector, this requirement is waived due to labour shortages, as confirmed in our interview with a migration officer at the Employment Service of Slovenia. In practice, this channels migrant women into care work irrespective of their qualifications or preferences. The bilateral agreement thus functions less as a direct recruitment tool for care and more as an institutional façade, obscuring the informal and network-based mechanisms. Together, these arrangements ensure a steady supply of labour while limiting mobility and bargaining power.

Another mechanism concerns dequalification and the extraction of skills. Many migrant women possess nursing qualifications (in our sample, four out of ten), yet recognition procedures are complex, costly, and time-consuming, with language requirements acting as a gatekeeper. These processes produce what Mezzadra and Neilson (2013) term internal borders, which restrict access to qualified positions while allowing entry into the labour market. As a result, migrant women are channelled into lower-status, physically demanding, and low-paid positions. At the same time, employers informally draw on their skills, creating a gap between formal position and actual work performed. As Nedžla explained in our interview: "A month later I got a position as a nurse, but my contract was still for a server. It's even below a caregiver. But I was working as a nurse." This enables the extraction of skilled labour at reduced cost, illustrating how qualifications are not simply unrecognised but actively downgraded and informally utilised in lower-ranked positions.

A further mechanism operates through temporal over-availability, extending labour beyond contractual limits. Due to geographical proximity, migrant workers maintain transnational family ties through frequent visits, which require additional time off. To secure this flexibility, they take on night shifts, overtime, and other undesirable working schedules. As Ranka described: "I asked the director to schedule me for four-to-five-night shifts next month, because they are 14 hours long, so I could have more days off." This "voluntary" flexibility enables employers to fill difficult shifts while extracting extended labour time. Transnational affective obligations are thus transformed into a resource that can be mobilised to stabilise labour shortages and intensify working conditions.

A related mechanism concerns the externalisation of social reproduction, including key aspects of migrant integration. As Breznik (2024) noted, bilateral agreements are framed primarily in economic terms, treating workers as labour resources rather than social subjects. While both employers and the state depend on migrant labour, the administrative costs of migration are largely borne by workers themselves, with several

interviewees reporting that they had to borrow money to cover these costs. Housing conditions, a dimension often overlooked in care migration research due to its focus on live-in arrangements, further intensify these pressures. Limited supply, high rents, and the absence of employer-provided accommodation impose significant financial burdens on migrant workers. As noted by a care home manager: "The relatives are also helping newcomers with accommodation because we cannot provide them with housing, and the cost of accommodation is such that one minimum wage is not enough." In the absence of comprehensive integration policies, migrant networks become essential for housing and everyday survival, while simultaneously shifting the costs of social reproduction onto migrants and their transnational ties.

Taken together, these mechanisms demonstrate that care extractivism results from the cumulative effects of legal, economic, and social arrangements that differentially incorporate migrant women into care labour.

6. Discussion

This article has conceptualised care extractivism as a relational and institutionally structured process that operates across and through state borders. The analysis has shown how care extraction emerges from the interaction of welfare restructuring, migration regimes, and broader geopolitical inequalities. In this sense, migration does not simply fill gaps in care provision but is constitutive of a regime that reorganises care labour under conditions of differential inclusion and constrained mobility. The findings demonstrate how bordering practices extend beyond territorial control and become embedded within labour market institutions, welfare arrangements, and everyday life (Mezzadra & Neilson, 2013). Mechanisms such as family reunification, employer-tied work permits, and the non-recognition of qualifications function as institutionalised forms of differential inclusion, incorporating migrant women into care labour under conditions that limit their autonomy while enabling the intensification of their work. In this way, access to mobility and employment becomes a means of regulating labour, making it available, flexible, and exploitable.

The article advances the concept of care extractivism by showing that extraction is actively produced through legal and policy frameworks that organise both the supply and the demand of care labour. On the one hand, the restructuring of Slovenia's care system has generated structural labour shortages through underfunding and privatization. On the other hand, migration regimes have channelled and immobilised migrant women within the care sector, while externalising key aspects of social reproduction onto migrant networks. Care extractivism thus operates as a multi-scalar regime that links domestic welfare transformations to transnational labour mobility.

These processes are shaped by historically and geopolitically structured inequalities specific to the post-Yugoslav semi-periphery (Blagojević, 2013). The analysis has shown that the Slovenia and BiH migration nexus reflects differentiated trajectories of post-socialist transformation, uneven incorporation into the European political economy, and the enduring effects of the postwar settlement in BiH. These conditions actively contribute to the production of labour mobility and the availability of workers for extractive care regimes. Situating care extractivism within this relational and multi-scalar framework allows for a more nuanced account of how local institutional arrangements, regional histories, and global political-economic dynamics intersect in the governance of care labour.

Finally, the analysis has broader implications for understanding the crisis of care in contemporary capitalism (Dowling, 2021; Fraser, 2022). Rather than being resolved through policy reform alone, care deficits are increasingly managed through the reorganisation of labour across borders, relying on structurally unequal conditions that enable the extraction of labour from migrant women. Recognising these processes shifts the analytical focus from labour shortages to the political and economic conditions that produce them, and from migration as a "solution" to migration as a constitutive element of extractive care regimes.

7. Conclusion

This article has conceptualised care-labour mobility between Slovenia and BiH as a manifestation of care extractivism on Europe's postwar semi-periphery, shaped by the legacies of Yugoslavia. By shifting analytical attention from private households to the state-organised system of residential care for older people, it has shown that welfare states themselves actively organise the transnational extraction of care labour through the interaction of fiscal governance, migration regimes, and labour market regulation.

The analysis demonstrates that care extractivism is not a contingent outcome of labour shortages, but a structural feature of contemporary capitalism, in which care systems are stabilised through the differential incorporation of migrant labour. The Slovenia and BiH case illustrates how this process operates through historically specific configurations of political and economic transformation, uneven European integration, and postwar political arrangements, which together shape the conditions under which labour becomes mobile and governable across borders.

The article advances care extractivism as a framework for understanding how European welfare states are increasingly sustained through transnational inequalities in social reproduction. As long as care systems rely on structurally unequal conditions that externalise costs and intensify labour, such strategies risk reproducing extractive dependencies. A more sustainable approach would require re-politicising care as a collective social responsibility, addressing the structural undervaluation of care work, and confronting the transnational inequalities on which current care regimes depend.

Acknowledgments

I would like to thank the reviewers and editors for their valuable suggestions for improving the manuscript.

Funding

This work was financially supported by the Slovenian Research and Innovation Agency (SRIA) within research program P5–0413 and research project J5–3104.

Conflict of Interests

The author declares no conflict of interest.

Data Availability

The data that support the findings of this study are available from the author upon reasonable request.

LLMs Disclosure

Artificial intelligence tools (OpenAI GPT-5.2) were used for language and stylistic editing, as well as in references formatting.

References

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Bhattacharya, T. (Ed.). (2017). *Social reproduction theory: Remapping class, recentering oppression*. Pluto Press.

Bajt, V., Breznik, M., & Kočkovska Šetinc, K. (2025). *From temporary to essential: Rethinking labour migration in Slovenia*. Mirovni inštitut. https://www.mirovni-institut.si/wp-content/uploads/2025/08/PolicyBrief_Slovenia_final_ENG.pdf

Belloni, R. (2009). Bosnia: Dayton is dead! Long live Dayton! *Nationalism and Ethnic Politics*, *15*(3), 355–375. https://doi.org/10.1080/13537110903372367

Black, R., & Gent, S. (2006). Sustainable return in post-conflict contexts. *International Migration*, *44*(3), 15–38. https://doi.org/10.1111/j.1468-2435.2006.00370.x

Blagojević, M. (2013). Transnationalisation and its absence: The Balkan semi-peripheral perspective on masculinities. In J. Hearn, M. Blagojević, & K. Harrison (Eds.), *Rethinking transnational men* (pp. 163–186). Routledge.

Bohle, D., & Greskovits, B. (2012). *Capitalist diversity on Europe's periphery*. Cornell University Press.

Bose, S. (2002). *Bosnia after Dayton: Nationalist partition and international intervention*. Hurst & Company.

Breznik, M. (2024). *Sustainable and socially just transnational sectoral labour markets for temporary migrants: JUSTMIG background report—Slovenia*. Peace Institute. https://celsi.sk/media/datasource/JUSTMIG_Background_Report_-_Slovenia.pdf

Breznik, M., Oruč, N., Bajt, V., Kurta, A., & Kočkovska Šetinc, K. (2025). *Educational institutions in the service of transnational migration? Cases of Slovenia and Bosnia and Herzegovina* (CELSI Discussion Paper No. 75). https://celsi.sk/media/discussion_papers/CELSI_DP_75_15uowt2.pdf

Cuban, S. (2013). *Deskilling migrant women in the global care industry*. Palgrave Macmillan.

Domazet, A., Domljan, V., Peštek, A., & Hadžić, F. (2020). *Održivost emigracija iz Bosne i Hercegovine*. Friedrich-Ebert-Stiftung. https://www.researchgate.net/publication/344304430_ODRZIVOST_EMIGRACIJA_IZ_BOSNE_I_HERCEGOVINE#fullTextFileContent

Döringer, S. (2020). The problem-centred expert interview: Combining qualitative interviewing approaches for investigating implicit expert knowledge. *International Journal of Social Research Methodology*, *24*(3), 265–278.

Dowling, E. (2021). *The care crisis: What caused it and how can we end it?* Verso.

Efendić, A. (2021). *How migration, human capital and the labour market interact in Bosnia and Herzegovina*. European Training Foundation (ETF). https://www.etf.europa.eu/sites/default/files/2021-06/migration_bosnia_and_herzegovina.pdf

Eurofound. (2020). *Long-term care workforce: Employment and working conditions*. Publications Office of the European Union. https://www.eurofound.europa.eu/en/publications/all/long-term-care-workforce-employment-and-working-conditions

Fraser, N. (2022). *Cannibal capitalism: How our system is devouring democracy, care, and the planet—and what we can do about it*. Verso.

Gutiérrez-Rodríguez, E. (2010). *Migration, domestic work and affect: A decolonial approach on value and the feminization of labor*. Routledge.

Harding, S. (1992). Rethinking standpoint epistemology: What is "strong objectivity"? *The Centennial Review*, *36*(3), 437–470.

Henig, D., Klepal, J., & Žíla, O. (2025). Towards an anthropology of fluxes in the post-Cold War world: An introduction. In D. Henig, J. Klepal, & O. Žíla (Eds.), *Bosnian fluxes: Belonging, caring, and reckoning in a post-Cold War semiperiphery* (pp. 1–22). Routledge. https://doi.org/10.4324/9781003508533

Hromadžić, A. (2016). Affective labour: Work, love and care for the elderly in Bihać. In S. Jansen, Č. Brković, & V. Čelebičić (Eds.), *Negotiating social relations in Bosnia and Herzegovina: Semiperipheral entanglements* (pp. 79–93). Routledge.

Hrženjak, M. (2025). Tacit strategies of labor migration management in senior care homes at the European (semi)periphery. *Social Politics: International Studies in Gender, State & Society*, *32*(4), 1184–1206. https://doi.org/10.1093/sp/jxaf018

Hrženjak, M., & Breznik, M. (2024a). Multiple interacting migration patterns in senior care in Europe's semi-periphery. In B. Aulenbacher (Ed.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 97–111). Sage.

Hrženjak, M., & Breznik, M. (2024b). *Transnacionalizacija domske oskrbe starejših ljudi v Sloveniji*. Mirovni inštitut. https://www.mirovni-institut.si/wp-content/uploads/2024/09/tedri-porocilo.pdf

Jahić, H., Hadžiahmetović-Milišić, N., Dedović, L., & Kuloglija, E. (2024). Diagnosing the issue: Understanding and combating medical brain drain in Bosnia and Herzegovina. *Naše gospodarstvo/Our Economy*, *70*(2), 12–23. https://doi.org/10.2478/ngoe-2024-0008

Jakovljević, V., Dominko, M., & Živanović, A. (2021). *Labour migration between Bosnia and Herzegovina and Slovenia*. Centre for Research and Studies (GEA); Institute for Economic Research (IER). https://www.gea.ba/wp-content/uploads/2021/10/BiH-to-SLO-Labor-Migrations-final-1.pdf

Jansen, S. (2015). *Yearnings in the meantime: "Normal lives" and the state in a Sarajevo apartment complex*. Berghahn Books.

Katona, N., & Melegh, A. (Eds.). (2021). *Towards a scarcity of care? Tensions and contradictions in transnational elderly care systems in Central and Eastern Europe*. Friedrich Ebert Stiftung.

Kolarič, Z., Kopač, A., & Rakar, T. (2011). Welfare states in transition: The development of the welfare system in Slovenia. In M. Stambolieva & S. Dehnert (Eds.), *Welfare states in transition: 20 years after the Yugoslav welfare model* (pp. 288–309). Friedrich Ebert Foundation. https://bpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/a/1299/files/2019/07/sti2015_kurtovic_maglajlic-and-rasidagic-socioeconomic-transformation-in-bh.pdf

Kussy, A., & Moll, L. (2023). Care extractivism in migration flows from postsocialist to Southern Europe and care municipalism as a decolonizing project. In S. S. Petkovska (Ed.), *Decolonial politics in European peripheries: Redefining progressiveness, coloniality and transition efforts* (pp. 59–75). Routledge.

Lewicki, A. (2023). East–West inequalities and the ambiguous racialisation of 'Eastern Europeans.' *Journal of Ethnic and Migration Studies*, *49*(6), 1481–1499. https://doi.org/10.1080/1369183X.2022.2154910

Lutz, H. (Ed.). (2011). *The new maids: Transnational women and the care economy*. Zed Books.

Majstorović, D. (2021). *Discourse and affect in postsocialist Bosnia and Herzegovina: Peripheral selves*. Palgrave Macmillan.

Mandič, S. (2016). Housing for care: A response to the post-transitional old-age gap. *Journal of European Social Policy*, *26*(2), 155–167.

Mezzadra, S., & Neilson, B. (2013). *Border as method; or, the multiplication of labor*. Duke University Press.

Nakano Glenn, E. (1992). From servitude to service work: Historical continuities in the racial division of paid reproductive labor. *Signs: Journal of Women in Culture and Society*, *18*(1), 1–43. http://www.jstor.org/stable/3174725

Obradović, N., & Jusić, M. (2021). *ESPN thematic report on long-term care for older people: Bosnia and Herzegovina*. European Social Policy Network. https://eespn.euro.centre.org/wp-content/uploads/2021/10/ESPN_BA_long-term-care_2021.pdf

OECD. (2025). *Health at a glance 2025: OECD indicators*. https://doi.org/10.1787/8f9e3f98-en

Oruč, N., & Kurta, A. (2024). *Background report Bosnia and Herzegovina: Sustainable and socially just transnational sectoral labour markets for temporary migrants*. Central European Labour Studies Institute; Center for Development Evaluation and Social Science Research. https://www.celsi.sk/media/datasource/JUSTMIG_background_report_BiH_29042024.pdf

Pašić, N. (2024). The demands of the labour market in Bosnia and Herzegovina and new trends in immigration. *Sarajevski žurnal za društvena pitanja*, *13*(1/2), 39–61.

Pistotnik, S., & Brown, D. A. (2018). Race in the Balkans: The case of erased residents of Slovenia. *Interventions*, *20*(6), 832–852. https://doi.org/10.1080/1369801X.2018.1492952

Pranjić, N., & Račić, M. (2020). Bosnia and Herzegovina. In Á. Ní Léime, J. Ogg, M. Rašticová, D. Street, C. Krekula, M. Bédiová, & I. Madero-Cabib (Eds.), *Extended working life policies* (pp. 163–172). Springer. https://doi.org/10.1007/978-3-030-40985-2_10

Sahraoui, N. (2019). *Racialised workers and European older-age care: From care labour to care ethic*. Palgrave Macmillan.

Samaluk, B. (2016). Migration, consumption and work: A postcolonial perspective on post-socialist migration to the UK. *Ephemera: Theory & Politics in Organization*, *16*(3), 95–118.

Schmitz-Pranghe, C., Oruč, N., Mielke, K., & Ibričević, A. (2020). *Making sure that the emigration of healthcare personnel from Albania and BiH works for all: What Germany can do* (BICC Policy Brief No. 8). Bonn International Center for Conversion. https://nbn-resolving.org/urn:nbn:de:0168-ssoar-71225-9

Shutes, I., & Chiatti, C. (2012). Migrant labour and the marketisation of care for older people: The employment of migrant care workers by families and service providers. *Journal of European Social Policy*, *22*(4), 392–405.

Šeherčehajić, E., & Ramić, A. (2022). Emigration-related attitudes of students of health studies in Bosnia and Herzegovina. *Iranian Journal of Health Sciences*, *10*(4), 27–34. https://doi.org/10.32598/ijhs.10.4.888.1

Triandafyllidou, A., & Marchetti, S. (2013). Migrant domestic and care workers in Europe: New patterns of circulation? *Journal of Immigrant & Refugee Studies*, *11*(4), 339–346.

Uhde, Z. (2025). The European care border regime: Theorising extraction, exploitation and East–West inequalities in cross-border care work in Central Europe. *The Sociological Review*, *74*(1), 141–159. https://doi.org/10.1177/00380261251360075

UN Women. (2023). *Baseline study on care economy in Bosnia and Herzegovina: Overview of the key denominators, policy and programming options*. UN Women. https://bosniaherzegovina.un.org/sites/default/files/2023-05/20230523_Care%20Economy_Study_ENG_0.pdf?utm_source=chatgpt.com

Ungerson, C., & Yeandle, S. (Eds.). (2007). *Cash for care in developed welfare states*. Palgrave Macmillan.

Wichterich, C. (2020). Who cares about healthcare workers? Care extractivism and care struggles in Germany and India. *Social Change*, *50*(1), 121–140. https://doi.org/10.1177/0049085719901087

Widding Isaksen, L. (2012). Transnational spaces of care: Migrant nurses in Norway. *Social Politics: International Studies in Gender, State & Society*, *19*(1), 58–77. https://doi.org/10.1093/sp/jxr029

Witzel, A. (2000). The problem-centred interview. *Qualitative Social Research*, *1*(1). https://doi.org/10.17169/fqs-1.1.1132

Yeates, N. (2009). Production for export: The role of the state in the development and operation of global care chains. *Population, Space and Place*, *15*(2), 175–187. https://doi.org/10.1002/psp.546

About the Author



Majda Hrženjak (PhD) is a sociologist and research associate at the Peace Institute—Institute for Contemporary Social and Political Studies in Ljubljana. Her research engages with the sociology of labour, gender studies, and social politics.

Social Inclusion
2026 • Volume 14 • Article 12023
https://doi.org/10.17645/si.12023

cogitatio

ARTICLE

Open Access Journal

Caring Communities in Urban Hungary: A Civil Society Perspective

Dóra Gábriel [1], Bettina Török [2], and Noémi Katona [3,4]

[1] Centre for Economic and Regional Studies, ELTE, Hungary
[2] University of Pécs, Hungary
[3] Centre for Social Sciences, ELTE, Hungary
[4] Corvinus University of Budapest, Hungary

Correspondence: Dóra Gábriel (gabriel.dora@krtk.elte.hu)

Submitted: 28 January 2026 **Accepted:** 18 May 2026 **Published:** 22 June 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

This article examines the development and impact of caring communities in a Hungarian town, situating the analysis within debates about the neoliberal restructuring of care and the authoritarian neoliberal state of Hungary. Drawing on Joan Tronto's ethics of care and various conceptualizations of caring communities as spaces of critical reflection and civic engagement, we investigate how civil society organizations act as facilitators and organizers of the local care landscape. Our empirical focus is a mid-sized urban center in southern Hungary, where demographic aging, shrinking welfare capacities, and a diverse social environment shape potential stakeholder cooperation. Based on qualitative research methods, including participatory fieldwork, semi-structured interviews, and focus groups, we analyze how local civil society organizations negotiate their roles in relation to municipal actors and other stakeholders, and the political impact they achieve on local governance through their work. The findings highlight both the potential and the limits of community-based initiatives: A shift can be observed at the municipal level, where concepts such as conscious aging and empowerment are increasingly recognized. However, civil society organizations are not able to fully prevent the reproduction of existing inequalities, and the participation of older adults remains limited.

Keywords

care for older people; caring communities; civil society organizations; Hungary

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

In the context of neoliberalism, care provision is increasingly subjected to market forces—a trend that has been widely discussed in the scholarly literature, including in relation to European welfare states. Within this framework, communities have been conceptualized as a potential "fourth pillar" of the care diamond (Razavi, 2007), offering an alternative to the ongoing processes of marketization and re-familialization of care. While caring communities have gained institutional recognition in countries such as Austria and Germany, critical scholarship has questioned the extent to which these initiatives genuinely challenge neoliberal restructuring, asking whether they are instead being co-opted into the same paradigms they seek to resist.

Although caring practices in urban life have become a growing area of study (Breinbauer et al., 2024; Kainradl et al., 2024; Wegleitner & Schuchter, 2018), the development, limitations, and potential of caring communities remain underexplored in Central and Eastern Europe. Given that the concept of caring communities inherently involves an examination of the interplay between civil society organizations, care regimes, and the state, it is crucial to consider how these initiatives unfold across differing political and institutional contexts. In particular, their emergence and function in authoritarian neoliberal states, such as Hungary, where welfare provision has undergone rapid transformation and is increasingly shaped by centralized, top-down decision-making (Szikra & Öktem, 2023), warrant closer examination. In this article, we examine the extent to which local state and civil society organizations possess the capacity to counterbalance these trends and implement a more democratic culture of care.

This article investigates how civil society organizations, as community initiators and organizers, are navigating a context in which the central state is systematically withdrawing from the provision of care for older people, democratic participation is in decline, and civil society operates under increasing constraints. The analysis employs the conceptual framework of caring communities (Wegleitner & Schuchter, 2018; Wegleitner et al., 2026) to explore local power dynamics and stakeholder relationships, with special attention to civil society organizations. We draw on Joan Tronto's conceptualization of care, including feminist care ethics (Tronto, 1993), and the understanding of caring communities by Wegleitner and Schuchter (2018) and Haubner (2020), who frame caring communities as loci of critical reflection on social relations, care needs, and civic engagement.

Our empirical focus is the town of Pécs, a mid-sized urban center in Baranya County, Hungary. The article examines the local care infrastructure, focusing on the development of stakeholder cooperation, and explores the impacts of community-oriented initiatives on local relations, collaborations, and social change. It is important to note that the research and data analysis were carried out before the 2026 elections, which marked the end of the Orbán regime. This research is conceived as a case study; therefore, its findings are not generalizable. However, they do highlight broader patterns in the operation of civil society organizations within a wider authoritarian context. The research asks (a) what challenges civil society initiatives face when attempting to promote a local democratic culture of care and (b) what impact they can achieve. The article will reflect on local political and economic constraints, with particular focus on the relationship with the municipality and other civil organizations. In doing so, we engage with broader questions about the local culture of care and the democratic potential of community-led initiatives.

2. How Can Care be a Democratic Common?

2.1. Democratic Values in Care Ethics and the Commons

In his most famous work, Hardin (1968) addresses the threat to societies posed by the depletion of shared resources, such as nature, water, or air, driven by human self-interest. Besides being physical, material entities, the commons are also understood as sets of social relations and social practices (Nightingale, 2019; Ticktin, 2024), which necessarily require a community (Caffentzis & Federici, 2014). This community is not based on identities, but on practices of care, collective contribution, and the reproduction of the commons in an egalitarian way. The commons can be interpreted as a type of governance, grounded in principles of participation, cooperation, and inclusiveness (Murillo et al., 2025). Organizing the commons involves more than managing shared resources; the process shapes and produces the community itself. One of the forms of organizing the commons is self-governance, requiring the individual engagement of citizens, through which they can learn acts of political engagement (Murillo et al., 2025). Governing the commons involves ethical and political commitments to inclusivity, cooperation, and polycentric decision-making, among others. At the same time, commoning is not just a political practice in which mutuality, participation, and empowerment take place, but one where asymmetrical relations and the pitfalls of government mechanisms may also arise (Nightingale, 2019; Zentai, 2025).

Feminist scholars argue that care is both a practice and a value, is relational, and human lives—at least for a few years—are necessarily dependent on the care they receive (Glenn, 2000; Held, 2006; Tronto, 2013). The ethics of care acknowledges emotions and emphasizes the moral obligation of fulfilling the needs of individuals for whom we have responsibility (Held, 2006). According to Held (2006, p. 15), care ethics recognizes caring relations, trust, and cooperation as moral phenomena that require moral evaluation:

> An ethic of care focuses on attentiveness, trust, responsiveness to need, narrative nuance, and cultivating caring relations…an ethic of care sees the interests of carers and cared-for as importantly intertwined rather than as simply competing. Whereas justice protects equality and freedom, care fosters social bonds and cooperation.

Thus, care and justice cannot be separated; justice is a necessary component of caring relationships.

While the ethics of care perceives that addressing intersectionality is key, including privileges and power relations in the fulfillment of care needs (Tronto, 2013), as well as the undervalued skills and competences of racialized carers (Raghuram, 2019), the theoretical limitation of the concept has been criticized. Hankivsky claims that care ethics often relies on homogenizing categories without attention to within-group differences, risking the reproduction of essentialist assumptions (Hankivsky, 2014). Her critique also concerns the conceptualization of power: Inequalities theorized by care researchers tend to treat systems of oppression as hierarchical rather than interlocking. Feminist care ethics entails the recognition and articulation of care needs and political sensitivity in particular. Social inclusion can be achieved through solidarity and various forms of social participation; thus, care is inevitably a political process (Bauder, 2016).

2.2. The Caring Community as an Instrument for Making Democracy?

In feminist critical literature, care and democratic values are interconnected. In a synthesizing piece, Glenn (2000) sees caregiving as a public social responsibility. Tronto (2013) argues that in caring democracies, family members do not collapse under care responsibilities, and the exploitation of paid care workers does not occur, nor does a pay gap or unequal care provision. In democratic societies, caring is based on participation and inclusiveness. "Democratic citizens are all engaged in provid[ing] and need care together; this *caring with* is a political concern and one that needs to be resolved through politics" (Tronto, 2013, p. 140). These ideas are strongly present in the discussion of caring communities. Caring communities are dynamic relations and places of critical reflection about care needs, involving multiple actors, where new relationships may emerge based on trust and engagement (Wegleitner & Schuchter, 2018; Wegleitner et al., 2020). Our analysis relies on this interpretation, treating the concept as a broad, relational understanding of care performed in physical space.

Drawing on Pateman (2012), participatory democracy refers to a form of citizen participation that involves deliberation, inclusion, and empowerment within society. Within this framework, democracy is not just a system where debates take place, but one in which citizens actively shape their institutions and environment; thus, democracy extends to everyday life. The concept of participatory democracy captures the idea of "making democracy" by emphasizing how democratic capacities, actors, and institutions are continuously produced through practice. The literature of caring communities also raises this point by linking democratic participation to active citizenship, in which individuals engage in and contribute to local society through mutual support and attentiveness (Kainradl et al., 2024; Wegleitner et al., 2026). Co-creation and collaborative learning enhance participants' sense of agency, thereby fostering a more democratic society.

Spatiality inevitably has a significant role in the participation, social relations, and everyday life of citizens (Purcell, 2003; Roxberg et al., 2020). Based on the concept of the "right to the city" (Harvey, 2003; Lefebvre, 1996), urban spaces are understood as critical arenas for resisting neoliberal restructuring, where citizens can demand inclusivity and shared control and reclaim urban spaces for democratic use. This perspective aligns with the concept of caring communities, which understand care as *doing* community in the places and spaces where acts of care occur. Urban spaces (Kainradl et al., 2024), neighborhoods (Sointu & Häikiö, 2024), care facilities (Gábriel & Katona, 2025), and community gardens (Rosol, 2012), among many other locations, are key sites for doing community reflectively. Caring neighborhood projects are initiatives that connect locals and foster social cohesion (De Donder et al., 2024). A caring neighborhood leads to an environment in which participants' happiness increases (De Donder et al., 2024) and reinforces the sense of informal mutual support (D'Eer et al., 2024).

In connection with the fact that the concept of the caring community is rooted in state-led programs in Germany, Austria, and Switzerland (Haubner, 2020; Wegleitner et al., 2020), critiques arose early after its introduction to the academic literature. While the state constructs and legitimizes a system of informal and gendered labor under the banner of community and voluntarism, promoting involvement in care for older people has become an exploitative political strategy. Haubner (2020) uses the concept of "indirect exploitation" to refer to the appropriation of unpaid and underpaid care labor to check the rising costs of reproduction and, indirectly, maximize profit. This exploitation allows the state to maintain the care system without committing significant resources to formal care provision. When the state outsources professional work to volunteers, it not only deepens welfare state retrenchment but also instrumentalizes communities

by idealizing them (van Dyk, 2018). Thus, this form of labor is inherently associated with the production of precarious conditions.

In authoritarian neoliberal states like Hungary, civil society initiatives, including caring communities, are particularly exposed to the challenge of cooptation. While civil society is often seen as a counterbalance to the state, civic organizations in authoritarian regimes may legitimize the system and reinforce state authority (Lewis, 2013). This can be seen when NGOs reduce pressure on the government to deliver higher-quality social services, or when the existence of the former creates the illusion of pluralism and alternatives, even if real policy initiatives are missing from the government agenda. Cox (2020) examines key developments in social welfare provision in East Central Europe, including Hungary, and the rise of nonprofit organizations as providers of welfare services since the early 1990s. The author finds that, despite the variety among the analyzed countries, civil society organizations' role in service provision has generally limited their ability to either pursue their own aims or preserve their autonomy, partly due to financial difficulties. In our research, we examine how far the initiatives we study have succeeded in building community and shaping attitudes, thereby contributing to a more democratic society.

3. The Local Care Regime

At the time of the research, in Hungary, care for older people was not a priority, unlike childcare, which was strongly supported by intense pronatalist social policies (Fodor, 2022). The Orbán regime considered families and children the main solution to demographic decline, while the needs of older adults were neither publicly discussed nor dealt with. The Hungarian care regime that targets older adults relies heavily on underpaid informal workers providing home-based care (Katona & Gábriel, 2026), while the state did not develop care provision through benefits or services, as reflected in the numbers. In 2025, the basic care allowance provided to relatives who were continuously caring for a chronically ill or severely disabled person was 125 EUR gross per month, while the increased care allowance was 188 EUR gross per month, paid to supporting family members caring for individuals with severe disabilities or significantly increased care needs (Hungarian Parliament, 2024).

The *National Strategy for Older People*, published in 2009, set the goals of promoting the active lifestyle and social participation of older people and shaping the image of older citizens, among others (Hungarian Parliament, 2009). The document also contains the idea of conscious aging; however, there are no critical reflections on the neoliberal interpretation of the concept, which emphasizes productivity and market-oriented solutions (Stončikaitė, 2024). Overall, the document lacks a critical evaluation of active aging and related neoliberal terms. No newer version has been released since 2009, indicating that the Orbán governments did not pursue a strategic vision for older people in the following 17 years (until its defeat in spring 2026). In the document *Strategy for Long-Term Care 2030* (EMMI, 2021), the concept of social policy is replaced by that of care policy. Meleg (2025) finds the core ideas of this care policy problematic because they reduce care to the individual, family, and community spheres by diminishing the role of the state and emphasizing the ideological influence of Christianity, thereby questioning the professional validity of social work. The ideas behind the care policy fit well with the authoritarian Hungarian government's narrative on care for the vulnerable. The principal critique of this care policy by Meleg (2025) is that it resembles and institutionalizes an ideology that foregrounds the caritas within

Christian social teaching—an approach that is paternalistic and stands in contrast to the core professional principle of empowerment in social work.

In Hungary, care provision is the responsibility of municipalities. The obligations concerning the social care provision of municipalities are written into the Social Act of 1993 (Hungarian Parliament, 1993), while policy concepts related to aging are often developed and implemented at the local level. Caring community initiatives are not institutionalized in Hungary, and community-based initiatives are not facilitated by the central state; however, local municipalities or civil society organizations may enhance the implementation of community-based ideas.

Located in southern Hungary, the population of Pécs has been steadily declining over recent decades (140,000 inhabitants in 2025), alongside an aging demographic profile, exacerbated by the outmigration of younger generations. However, Pécs is a unique town in several respects, particularly in its political landscape and civil activism. Politically, the town has followed a shifting trajectory since the political transition in 1989. Although the ruling Fidesz party governed Pécs for two periods (1994–1998 and 2009–2019), the municipality has been led by opposition-backed mayors for the rest of the time. At the time of the research, the municipality was led by an independent mayor supported by a coalition of opposition parties since 2019. Pécs is governed by a politically diverse municipal assembly in which neither side holds an absolute majority. Therefore, the political landscape is rather different from that of many mid-sized Hungarian towns. According to the Hungarian Central Statistical Office, 956 civil society organizations (402 foundations and 554 associations) were operating in the town in 2024, a high number relative to the population. Regarding aging, Pécs is one of the few Hungarian municipalities to have officially adopted a policy concept on aging (discussed in detail below), which reflects on welfare responsibilities and societal change.

4. Methodology

4.1. Research Methods

The research applied a qualitative methodology. In the first step, local policy documents were analyzed. We studied all the related legislative documents and policy proposals published by the municipality and civil actors associated with the living conditions and social provision for older citizens, with a particular focus on the Policy Concept on Aging Pécs (Pécs Megyei Jogú Város, 2022), Civil Concept 2022–2026 (Pécs Megyei Jogú Város Önkormányzata, 2021), and the Local Equal Opportunities Program (Pécs Megyei Jogú Város Önkormányzata, 2023). The empirical research involved participatory fieldwork, semi-structured interviews, and focus groups. Organizations were selected with the help of local partners, while we also drew on our prior knowledge of the civil society landscape of Pécs. To build and strengthen relationships within the selected communities, we attended various community events, such as open lectures for older adults, joy dance sessions, thematic gatherings, and workshops. Besides gaining insight into social activities, the fieldwork helped to build trust with the community organizers and members. Furthermore, it also provided a pool of interviewees from which we selected the focus group participants. Three focus groups were conducted with various stakeholders, including experts, founders of local civil associations, community developers, older adults, municipal employees, heads of social institutions, healthcare professionals, volunteers, and academics working on aging or social policy (N = 15). The first focus group took place in March (n = 4), the second in May (n = 4), and the third in December, 2025 (n = 7). We conducted

12 individual semi-structured interviews with community organizers, heads of civil associations, heads of social institutions, municipal employees, academic researchers, and members of local communities between 2023 and 2025.

The research project relied on participation and applied engaged research methods to establish and sustain dialogue with the study participants (Morrison & Sacchetto, 2018). The approach indicates that researchers' commitment was continuous, despite challenges that may have arisen in interactions. In our research design, engagement involved returning findings to the communities and facilitating discussions about our research results. For the data analysis, we used the iterative research method (Fairfield & Charman, 2019). This methodological approach involves theorizing, data collection, and data analysis being negotiated repeatedly rather than in a fixed linear sequence. It relies on a dialogue with the data, in which emerging evidence leads to revisiting assumptions and updated theoretical ideas guide further inquiry. Iterative qualitative research helps generate explanations while mitigating the risk of bias in the analysis. The analysis primarily focuses on the work of civil society organizations, while referring to the macro-level policy context where relevant.

One of the authors, Bettina Török, had a dual role in this research. While she was a PhD student at the time of the empirical data collection, she was also a member of the Council on Aging and a co-founder of a civil association based in Pécs. This positionality provided experiential knowledge of the overall dynamics of the town's civil society, including decision-making processes, internal practices, alliances, and fault lines. At the same time, it required critical reflection on potential biases, such as over-identification with participants or partial interpretation of the interviews. To navigate this insider-outsider dynamic, the co-authors engaged in constant dialogue and collaborative data interpretation.

4.2. Selected Civic Initiatives

For the sociological fieldwork, we selected a few organizations identified as caring communities. These organizations see older people as a heterogeneous group of capable citizens with highly different needs and abilities. According to them, these special needs do not depend on the age cohort to which individuals belong, and reflexivity regarding ongoing societal changes should be incorporated into both community life and social policies. Author Dóra Gábriel attended the events of four civil society organizations, which slightly vary in their goals, areas, and approaches, while they all address the experiences of aging citizens. The first was a series of open lectures for older adults that takes place every other week at the University of Pécs. The idea was developed by a researcher and university lecturer specializing in later-life education, successful aging, and lifelong learning. Besides attending the lectures, members also organize themselves and make friends after the event. The second organization is a foundation that seeks to create a local conscious aging ecosystem and to build a conscious aging network connected to related European movements. They have launched several initiatives, such as developing a board game on intergenerational cooperation and a workshop on aging, and they frequently organize community meetings in the city center. The third is a civil society organization located in a community building close to the town's main pedestrian street that provides space for events, meetings, and educational courses for older people. The building is maintained by the municipality and is frequently visited by different groups and clubs. The fourth is an association that brings together patients with Parkinson's Disease to promote their rehabilitation and represent their general and specific interests. They organize social events, excursions, and joy dances in public spaces of the town to raise awareness of their disease.

4.3. Ethical Considerations

After providing information on the goal of the study, all interviewees signed a consent form outlining their rights and procedures for data management. Interviewees were aware that they had the right to withdraw their consent at any time and to terminate the interview; furthermore, they could refuse to answer questions asked by the interviewer. Participants granted permission to use excerpts from the interviews after sensitive data had been anonymized.

5. Municipal–Civil Society Organization Relations in the Local Care Landscape

Cooperation in the field related to aging is characterized by the dominance of informal networks and is mainly determined by personal relationships. Professional and civil initiatives often start with professionals seeking partners within their own circle of acquaintances. This allows a flexible and rapid response, but increases the dependence on individuals and does not guarantee long-term sustainability. As a co-founder of a foundation explained:

> Through personal relationships, a person sets off with their own struggles….You start, you do it, and you look for collaborators across sectors or across professions, drawing on your own network of connections. I think this is strengthening in its own way and gaining momentum, and after a while, it [the initiative] will become strong enough. In my view, this will be the solution…people will start to realize they want to join, they will see the strength behind it, and over time, they will come to believe in it.

Institutional frameworks for cooperation are rare. Typically, parallel initiatives are intertwined at the individual level. Formal cooperation between organizations is much more difficult to achieve because such collaborations are not always considered genuine, as they are not based on consciously developed, long-term professional structures. However, informal cooperation is seen as the basis for strong networks that can attract more participants who will engage with the activities of these organizations.

The informal networking of various civil initiatives was interpreted as an "ecosystem" of aging in Pécs by one of our informants. In her view, it involves diverse and heterogeneous imaginaries about care, with the involvement of various stakeholders with different skills, capacities, and agendas. However, the network is loose, largely ad hoc, and unstructured. Based on the interviews, a picture emerges of a local "ecosystem" characterized by both strong civic activism and a lack of institutional support. Although some professional networking has started in recent years, the municipality is more of a passive supporter than an active coordinator. However, one of the civil society organizations acts as an important meeting point where smaller organizations can collaborate. "We started to form networks like this, and that's a really great thing, but the municipality would rather let it happen than actually support it," claimed one of the community organizers. They continued:

> The local government isn't lifting a finger. The local government is just happy we exist, period….They've never supported us. Now we'd like a clubhouse. It's a bit like daycare, though obviously it isn't. So, a place where you can sit down, make coffee or tea, order newspapers, things like that. We don't have a space, nothing.

Participants underlined that despite the lack of stable support of the local municipality, civil society organizations and the civil service providers are key drivers of local initiatives on aging, as well as retirees' organizations, health and social care institutions, faith-based providers, and informal communities (e.g., hiking groups and joy dance networks). Many institutions and communities related to aging operate entirely outside formal structures.

Volunteering is one of the most important resources of local initiatives related to aging and community work. A significant number of the programs, especially the civic and community-based activities, rely almost entirely on volunteers. This model provides flexibility but also leads to serious issues with sustainability:

> [For more impact, we] would need many more people and much more time. We would have to promote this [initiative] and attract people, but we do not really have the [capacity] to do so. Everyone is a volunteer; we work for free, so there are basically just the two of us doing this. (Community organizer)

In many civil society organizations, all actors, including community organizers, trainers, and course leaders, work without remuneration. In these cases, volunteering is not complementary but a fundamental part of the work. Besides this, local government initiatives often require voluntary contributions from civil society organizations. In many cases, expert work is also expected to be provided free of charge, which puts an unsustainable strain on human resources in the long term. These findings strongly confirm Cox's (2020) analysis of civil society organizations in East Central Europe, which shows that while these actors are increasingly incorporated into welfare provision, they are simultaneously constrained by ongoing austerity measures. Additionally, this can be understood as an example of labor exploitation in caring communities, which Haubner (2020) critiques.

6. Political Impact: Democratic Potential of Cooperation and Local Tensions

The Policy Concept on Aging Pécs was published in 2022 with the intention of assessing and reflecting on the emerging needs of older adults living in the city. The document states that the common interest of the municipality and civil society organizations is to ensure long-term, effective cooperation to address new challenges and shape attitudes. The document highlights the importance of self-care and consciousness in the aging process, while pointing out that the deterioration of economic and social conditions in Hungary has significantly reduced municipalities' room for maneuver. This is an interesting point made by the authors (who are not named in the policy concept), which suggests that the municipality not only recognizes the increasing care gap but is also willing to take responsibility and open to alternative solutions to handle local care needs. The role of civil society organizations and the involvement of volunteers in care provision are also mentioned, as are new ideas to be implemented, such as a community center for older adults and the development of more community spaces.

The Policy Concept on Aging has been a major catalyst for deepening relations between the actors. The preparation of the document started in 2021, was coordinated by a civil society organization at the request of the municipality, and the professional content was compiled by professionals working in the field. The principle of involvement was wide-ranging: Not only representatives of the institutional system, but also civil society organizations, community developers, and concerned citizens were approached. This broader horizon provided an opportunity to bring together different perspectives and extend cooperation in a

democratic way. The process was therefore linked to a participatory paradigm shift, in which the involvement of local actors and collective thinking was expected.

However, conflicts between the actors were also present, stemming from several sources: attitudinal and generational differences, gender-related tensions, professional rivalry, and resource imbalances. Attitudinal differences are one of the major obstacles to successful dialogue. A few older male professionals espoused rather conservative ideas and were critical of the sharply different, integrative perspectives on aging held by the majority of the civil actors who joined the Council in the 2020s. In contrast, the younger, mostly female civil actors criticized the dominance of older male delegates in the Council on Aging and similar forums for their short-term mindset and status anxiety, which, in their view, makes it difficult to adopt professional standards or innovations, undermines joint work, and hinders progress:

> The biggest problem with the Council on Aging is that only the very old people are sitting there, who can only think in the very short term—I could even say, in a very narrow way: It's all about pensions, about what benefits they get….Whereas the kind of thinking we immersed ourselves in—what long-term measures would be worth implementing, starting from raising awareness, through active aging, to intergenerational relations…so, we considered many aspects—is very far from their way of thinking. (Head of social institution)

Thus, these tensions reflect a conflict between attitudes and goals, but are actually rooted in gender and generational differences.

One of the most critical obstacles to the development of care and services for older people in Pécs is the lack of stable and sufficient resources. The implementation of the Local Equal Opportunities Program, the Civil Concept, and other action plans for older people largely depend on grant funding. The Local Equal Opportunities Program 2023–2027 is a strategic document without which the municipality cannot participate in Hungarian and EU-funded tenders. Its goal is to establish professional partnerships through cooperation between the state, municipality, church, and civil society organizations. Civil Concept 2022–2026 is a strategic document that analyzes the role and opportunities of the town's civil sector. It highlights that non-profit organizations in Pécs are key players in carrying out community and social tasks and are strategically important partners for the local government in providing local public services. Plans are often put into effect only once organizations have won specific tenders, which puts implementation on a highly uncertain footing. Although TOP Plus funds can provide an opportunity to launch new projects, success is not guaranteed, and implementation can be delayed. The lack of resources often leaves plans and ideas unrealized, causing frustration among professionals and mistrust in the community. The reliance on the grant system makes long-term strategic planning virtually impossible, as all development is dependent on securing grants.

The authors of the Policy Concept on Aging noted that having delegates in the Council on Aging is an important political impact of their work, and that the concept of conscious aging has already been incorporated into municipal discourse. As one of the authors said: "At the policy level, we shape the space and the way of thinking through municipal documents. So, it's really exciting that we say 'conscious aging,' and more and more people understand what it means—even at the municipality." Actors interpreted the acknowledgment of their persistent work at the municipal level as a sign of devotion to further projects. In their approach to "conscious aging" they also foreground community development and the crucial role of

social relationships, including co-housing initiatives. Therefore, they do not engage with the neoliberal implications of this concept, as they interpret conscious aging not as a call for individual responsibility and self-care, but rather as a collective project aimed at building supportive social environments and communities—both locally and at the city level, supported by the state—that care for older people and address aging as a long-term, socially embedded process.

7. Perceived Shift in Local Relations

7.1. Central Concepts and Goals

The interviews and focus groups suggested attention to two related topics: shaping attitudes in local society and the necessity of building communities. Civil society organizations in Pécs strongly rely on these elements when discussing their desired and actual impacts. Shaping attitudes includes raising awareness, fostering solidarity at the societal level, and transferring knowledge across generations:

> Aging is not only an issue for older adults. We would like young people to start dealing with it as well, and until now it hasn't really been typical to have programs designed for that—[those] not only involving young people, but thinking about the whole issue [aging] together, because this should be a social responsibility. (Founder of a foundation)

The fact that conscious aging is an issue incorporated in the Policy Concept on Aging is perceived as one of the main impacts of civil society organizations:

> The small-scale ecosystem-building we started here in Pécs nearly three years ago is now showing visible results, as the mindset itself has been incorporated into the much-talked-about policy concept. In this regard, we can achieve small things within our own remit—like running a club every month, organizing events, and finding and supporting every innovative initiative and idea related to older people that aligns with the conscious aging approach. (Co-founder of a foundation)

Community building includes network formation, enhancing members' social participation, and encouraging individuals to contribute their own skills to the community. One example of this is a sewing workshop initiated by a woman who regularly participates in the foundation's events. The group serves as a safe space for women of all ages who can talk about their daily challenges while enjoying time together.

Stakeholders also raised questions about what community means and how it can be achieved. There is consensus among the interlocutors that social relationships are particularly important for older people to avoid loneliness, and social participation can contribute to greater well-being. As one of the community organizers put it: "One of the keys to successful aging is not being alone. Loneliness kills." A cofounder of a foundation argued as follows:

> It's very important to me that we actually get people to start speaking honestly with one another, to learn the culture of how to argue and debate respectfully—because then, later, we can really find solutions to social problems. If we can talk to one another while paying attention to the other person, we will understand their point of view.

The community aims to make an impact on local society by activating and regularly challenging its members collectively to achieve social change. In this case, *caring with* (Tronto, 2013) is inherently political, embedded in a democratic learning process (Wegleitner et al., 2026) where community encounters not only strengthen social relations but also lead to higher levels of social participation through democratic co-creation.

7.2. Limits of Participation

The question of who can actually participate in and become members of these communities was addressed in various ways by the stakeholders. The participation of older adults is strongly shaped by intersectional factors, among which educational background is particularly significant. People with lower levels of education (less than a secondary-school leaving certificate) do not dare enter the university building to attend open seminars. This implies that the location and the environment of events affect the willingness to participate. The digital divide is also an influential factor, preventing certain individuals from participating. According to community initiators, people who lack knowledge of online communication (e.g., email, Facebook) drop out. Additionally, Roma people and older adults with lower social status hardly ever take part in the community events of the abovementioned groups. However, they may join the Retirees' Association's events, where the entry threshold is very low and the group is less exclusive. The current research also found a gender imbalance in favor of women among the participants. Male participants were either brought by their wives or seeking new partners, while some men were "afraid to come," according to community organizers.

The interviewees did not explicitly address the political divide among participants. In several civil society organizations and communities, this absence can be interpreted as reflecting a shared understanding of political views within the specific group. However, in one local community, the group leader stated that discussing politics is explicitly prohibited at community events, which, in her view, creates a relaxed atmosphere.

Overall, the civil society organizations we investigated primarily focus on *active* older people, and do not reflect much on their (lack of) efforts to involve people with greater care needs in their programs. An Austrian case study mentions health constraints, language barriers, and earlier experiences of exclusion as possible drivers of high dropout rates (Wegleitner et al., 2026). In our case, patterns of non-participation can also be understood in relation to structural inequalities. Limited cross-class interaction and social solidarity might reduce individuals' confidence in participating in mixed social settings. These dynamics are further reinforced in contexts where civil society is marginalized, leading to selective participation rather than broad inclusion (Gerő et al., 2023). Ultimately, such exclusions reflect the broader effects of an authoritarian–neoliberal regime that constrains civic spaces and reproduces social hierarchies.

7.3. Intergenerational Approach in Desired and Implemented Ideas

While representatives of civil society organizations had many goals, such as introducing intergenerational cohousing, establishing a care facility, and creating an intergenerational learning platform supported by civil actors, some of these ideas seem to remain long-term plans. A notable exception is the planned intergenerational cohousing initiative, which is already the subject of pilot research and incorporated into the Local Equal Opportunities Program. The initiators are aware that it would solve the housing problems of only a limited number of people living in the town; however, they believe it could be an innovation not only

in Pécs but also serve as a good example for other municipalities. That is why they are sharing the idea with other stakeholders:

> We went to the [group name] meeting to talk about this and to see, to monitor, how they react. We also discussed it at a gerontology conference so that this housing program would become a topic at the national level as well. (Founder of a foundation)

The question remains: How much is the municipality willing to help launch the idea?

Despite the challenges, various ideas have already been realized, such as the transfer of knowledge about conscious aging among older citizens and the dissemination of knowledge through social media implemented by a foundation. Further, a university course has been opened up to older adults by a community organizer, where older citizens are able to participate and engage in conversation with students on aging and related issues: "They attend my class….It's been hugely successful; they love it. My retirees sit in one row, my undergraduates in another, and they communicate—the classes are so good, I love them, and they appreciate them very much." Another product of activist efforts is a team game that shapes attitudes and raises awareness about older people. It intertwines individual life stories with broader historical transformations. While it aims to educate, it also fosters a sense of community, and participants are invited to Foundation events to continue engaging with the topic. These initiatives have an impact not only on older generations but also on younger ones by creating the space to exchange ideas and draw on the knowledge associated with diverse life experiences.

8. Discussion and Conclusion

In this article, we raised the question of the democratic potential of caring communities navigating in a mid-sized Hungarian town in an authoritarian state where care for older people is neglected and severely underfinanced. We observed the economic constraints under which civil society actors operate; studied the tensions and forms of cooperation within the local care landscape; and identified the impacts of community-based civic initiatives on local governance through a critical lens, highlighting the limitations of these initiatives. One of the contributions of this study lies in its illustration of how dynamics already discussed in the literature (Haubner, 2020; Rosol, 2012) also manifest within the Central and Eastern European context, where austerity measures and dependency on state funding further limit the autonomous and critical potential of civil society actors (Cox, 2020). The article examines a case in which local care culture is undergoing transformation and in which a caring democracy, as described by Tronto (2013), is emerging as a relatively new approach, shaped by ongoing struggles and conflicts within the local care landscape.

In a caring democracy, care-related tasks are not exclusively assigned to institutions, but citizens feel responsible for each other and engage in providing care in a conscious way (Tronto, 2013). Drawing on Tronto's concept of caring democracy, care is necessarily a political act. In the case study, representatives of civil society organizations articulated an approach to aging and care that reflected many elements of Tronto's framework. Although they framed their aims and activities in terms of "conscious aging," their work did not align with neoliberal ideas of individualized self-care; rather, it emphasized community building, the active social participation of older adults, and a long-term, intergenerational perspective on aging. Even though

community initiators did not consider themselves political actors, they tended to reject involvement in party politics, including the public articulation of views and reflections on the authoritarian government and its politics, to remain neutral. Nevertheless, they engaged in highly active political work at the local level through their involvement in elaborating the city-level Policy Concept on Aging and by joining the Council for Older People, while continuing to implement tasks that would otherwise fall to the state.

The shrinking room for maneuver of civil society organizations in Hungary, which is otherwise largely discussed in the literature on authoritarian regimes (Gerő et al., 2023), was only addressed by stakeholders in our research concerning the lack of resources, which manifested at several levels: the withdrawal of resources from small NGOs by the state, the dependence on grants due to the absence of state funding, and the absence of a financial basis for long-term, sustainable institutional operation. While civil actors complained about the municipality's lack of support, they emphasized that they remain independent entities because of the lack of such formal engagement.

Additionally, their participation in the development of the policy document, and their active engagement in the Council—even though the Council's mandate is limited to commenting on policies, rather than approving or vetoing them—can be interpreted as forms of participatory democracy in the sense described by Pateman (2012), who argues that local governance fosters democratic capacity through civic learning processes.

According to Nightingale (2019, p. 21), commoning is a performative action, where the focus is on the making: "Commoning is a set of practices and performances that foster new relations and subjectivities, but these relations are always contingent, ambivalent outcomes of the exercise of power." While the commons may contribute to an egalitarian society, they entail the risk of co-optation and the creation of social divisions (Caffentzis & Federici, 2014). The struggle of community-based initiatives with other civil society organizations that were not open to their ideas shows that shifting perceptions of care and working towards a new culture of care in a socio-political environment where these ideas are new involves a difficult journey.

Due to its democratic, non-hierarchical nature, the commons are often referred to as a struggle against exclusion (Nightingale, 2019). The danger of the commons can be identified in exclusionary practices within communities, while intersectionality and diverse individual experiences of power relations are also present (Nightingale, 2019). Our analysis indicated that, beyond the uneven chances for stakeholders, there were also fault lines in participants' access to particular communities. We observed that newly emerged civil society organizations mainly target active older adults, raising questions about equal opportunities and accessibility for a large group of people living in the town. Additionally, although the caring community initiatives sought to promote the active participation of all older people and to be inclusive, the interviews revealed that several groups remained excluded, including people from lower social classes, individuals with lower levels of education, ethnic minorities, and men.

While avoiding normative claims, it can be observed that the current development of local civil society appears to outweigh the constraints posed by the limited room to maneuver. Overall, Pécs is a town that demonstrates a deliberate commitment to fostering a more caring local society on a policy level. At the same time, community-based civic initiatives operate in a rather fragile environment and do not fully reach all potential groups of older adults. A limitation of the current research is that it did not include retired individuals who are not engaged in local community activities. As a result, their perspectives are absent from

the analysis. Incorporating this group's views would provide a more comprehensive understanding of the local culture of care.

Acknowledgments

We would like to thank the reviewers and editors for their feedback and comments. We also thank our colleagues at the Institute for Regional Studies, CERS, for their insights on an earlier version of the manuscript.

Funding

This research was funded by the National Research, Development and Innovation Office (Grant no. NKFI PD-142319, PI: Dóra Gábriel, and NKFI K-146630, PI: Margit Feischmidt).

Conflict of Interests

The authors declare no conflict of interest.

Data Availability

Due to the nature of the research, data sharing is not applicable to this article.

LLMs Disclosure

ChatGPT was used for language editing, including grammar checking and stylistic refinement.

References

Bauder, H. (2016). Possibilities of urban belonging. *Antipode*, *48*(2), 252–271. https://doi.org/10.1111/anti.12174

Breinbauer, V., Franz, Y., Lindsberger, M., Saltiel, R., & Strüver, A. (2024). Urban cultures of care. *UXUC: User Experience and Urban Creativity*, *6*(1), 10–23. https://doi.org/10.48619/UXUC.V6I1.902

Caffentzis, G., & Federici, S. (2014). Commons against and beyond capitalism. *Community Development Journal*, *49*(Suppl. 1), i92–i105. https://doi.org/10.1093/cdj/bsu006

Cox, T. (2020). Between East and West: Government–nonprofit relations in welfare provision in post-socialist Central Europe. *Nonprofit and Voluntary Sector Quarterly*, *49*(6), 1276–1292. https://doi.org/10.1177/0899764020927459

D'Eer, L., Chambaere, K., Van Den Block, L., Dury, S., Sallnow, L., Deliens, L., Smets, T., & Cohen, J. (2024). How compassionate is your neighborhood? Results of a cross-sectional survey on neighborhood participation regarding serious illness, death, and loss. *Death Studies*, *48*(8), 810–819. https://doi.org/10.1080/07481187.2023.2283449

De Donder, L., Stegen, H., & Hoens, S. (2024). Caring neighbourhoods in Belgium: Lessons learned on the development, implementation and evaluation of 35 caring neighbourhood projects. *Palliative Care and Social Practice*, *18*. https://doi.org/10.1177/26323524241246533

EMMI. (2021). *Tartós ápolás-gondozásra vonatkozó stratégia 2030*. https://cdn.kormany.hu/uploads/document/c/c6/c68/c68381aafe390e0744e99b10df3a98b3bd67ce67.pdf

Fairfield, T., & Charman, A. (2019). A dialogue with the data: The Bayesian foundations of iterative research in qualitative social science. *Perspectives on Politics*, *17*(1), 154–167. https://doi.org/10.1017/s1537592718002177

Fodor, E. (2022). *The gender regime of anti-liberal Hungary*. Springer International Publishing. https://doi.org/10.1007/978-3-030-85312-9

Gábriel, D., & Katona, N. (2025). Caring communities in senior care—Municipal practices and civic initiatives in rural Hungary. *Berliner Journal Für Soziologie*, *35*, 597–612. https://doi.org/10.1007/s11609-026-00590-x

Gerő, M., Fejős, A., Kerényi, S., & Szikra, D. (2023). From exclusion to co-optation: Political opportunity structures and civil society responses in de-democratising Hungary. *Politics and Governance*, *11*(1), Article 5883. https://doi.org/10.17645/pag.v11i1.5883

Glenn, E. N. (2000). Creating a caring society. *Contemporary Sociology*, *29*(1), 84–94. https://doi.org/10.2307/2654934

Hankivsky, O. (2014). Rethinking care ethics: On the promise and potential of an intersectional analysis. *American Political Science Review*, *108*(2), 252–264. https://doi.org/10.1017/S0003055414000094

Hardin, G. (1968). The tragedy of the commons. *Science*, *162*(3859), 1243–1248.

Harvey, D. (2003). The right to the city. *International Journal of Urban and Regional Research*, *27*(4), 939–941. https://doi.org/10.1111/j.0309-1317.2003.00492.x

Haubner, T. (2020). The exploitation of caring communities: The elder care crisis in Germany. *Global Labour Journal*, *11*(2). https://doi.org/10.15173/glj.v11i2.4090

Held, V. (2006). *The ethics of care: Personal, political, and global*. Oxford University Press.

Hungarian Parliament. (1993). *Act III of 1993 on social administration and social benefits*. https://net.jogtar.hu/jogszabaly?docid=99300003.tv

Hungarian Parliament. (2009). *OGY resolution on the national strategy for older people. 81/2009. (X. 2.)*. https://mkogy.jogtar.hu/jogszabaly?docid=a09h0081.OGY

Hungarian Parliament. (2024). *Act XC of 2024 on the central budget, §71 (3c)*. https://net.jogtar.hu/jogszabaly?docid=a2400090.tv

Kainradl, A., Kukovetz, B., Pupic, D., Sprung, A., & Wegleitner, K. (2024). Social participation of older people with migration experiences through the lens of active citizenship and caring communities. *Österreichisches Jahrbuch für Soziale Arbeit*, *6*(1), 37–58. https://doi.org/10.30424/OEJS2406037

Katona, N., & Gábriel, D. (2026). The quiet collapse: Authoritarian neoliberalism and the crisis of care of older people in Hungary. *Economy and Society*, 55(2), 301–323. https://doi.org/10.1080/03085147.2026.2632445

Lefebvre, H. (1996). *Writings on cities*. Blackwell Publishers.

Lewis, D. (2013). Civil society and the authoritarian state: Cooperation, contestation and discourse. *Journal of Civil Society*, *9*(3), 325–340. https://doi.org/10.1080/17448689.2013.818767

Meleg, S. (2025). Mi a gondoskodáspolitika? Megújítási vagy ideológia vezérelt kiszorítási kísérlet? *Párbeszéd: Szociális Munka Folyóirat*, *12*(1), 1–14.

Morrison, C., & Sacchetto, D. (2018). Research ethics in an unethical world: The politics and morality of engaged research. *Work, Employment and Society*, *32*(6), 1118–1129. https://doi.org/10.1177/0950017017726947

Murillo, D., Guinart, P., & Arenas, D. (2025). The ethics of commons organizing: A critical reading. *Journal of Business Ethics*, *196*(1), 3–20. https://doi.org/10.1007/s10551-024-05706-y

Nightingale, A. J. (2019). Commoning for inclusion? Commons, exclusion, property and socio-natural becomings. *International Journal of the Commons*, *13*(1), 16–35. https://doi.org/10.18352/ijc.927

Pateman, C. (2012). Participatory democracy revisited. *Perspectives on Politics*, *10*(1), 7–19. https://doi.org/10.1017/S1537592711004877

Pécs Megyei Jogú Város. (2022). *Idősügyi Koncepció*. https://www.eeipecs.hu/wp-content/uploads/PMJV_Idosugyi-koncepcio.pdf

Pécs Megyei Jogú Város Önkormányzata. (2021). *Civil Koncepció 2022–2026*. https://www.ckh.hu/sites/default/files/fajlok_hir/2021/2021-09-30-civilkoncepciopecs2020210930.pdf

Pécs Megyei Jogú Város Önkormányzata. (2023). *Helyi Esélyegyenlőségi Program*. https://pvfzrt.hu/wp-content/uploads/2024/07/hep_2018_2023.pdf

Purcell, M. (2003). Citizenship and the right to the global city: Reimagining the capitalist world order. *International Journal of Urban and Regional Research*, *27*(3), 564–590. https://doi.org/10.1111/1468-2427.00467

Raghuram, P. (2019). Race and feminist care ethics: Intersectionality as method. *Gender, Place & Culture*, *26*(5), 613–637. https://doi.org/10.1080/0966369X.2019.1567471

Razavi, S. (2007). *The political and social economy of care in a development context*. United Nations Research Institute for Social Development.

Rosol, M. (2012). Community volunteering as neoliberal strategy? Green space production in Berlin. *Antipode*, *44*(1), 239–257. https://doi.org/10.1111/j.1467-8330.2011.00861.x

Roxberg, Å., Tryselius, K., Gren, M., Lindahl, B., Werkander Harstäde, C., Silverglow, A., Nolbeck, K., James, F., Carlsson, I.-M., Olausson, S., Nordin, S., & Wijk, H. (2020). Space and place for health and care. *International Journal of Qualitative Studies on Health and Well-Being*, *15*(Suppl. 1), Article 1750263. https://doi.org/10.1080/17482631.2020.1750263

Sointu, L., & Häikiö, L. (2024). Doing community amid tension and vulnerability: Involvement and control in older adults' accounts of their neighbourhood. *Social Inclusion*, *12*, Article 8436. https://doi.org/10.17645/si.8436

Stončikaitė, I. (2024). Later-life creativity and successful aging in neoliberal agendas. *The Gerontologist*, *65*(1), gnae125. https://doi.org/10.1093/geront/gnae125

Szikra, D., & Öktem, K. G. (2023). An illiberal welfare state emerging? Welfare efforts and trajectories under democratic backsliding in Hungary and Turkey. *Journal of European Social Policy*, *33*(2), 201–215. https://doi.org/10.1177/09589287221141365

Ticktin, M. (2024). Care as political revolution? *Focaal*, *2024*(98), 64–70. https://doi.org/10.3167/fcl.2024.980105

Tronto, J. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.

Tronto, J. (2013). *Caring democracy: Markets, equality, and justice*. New York University Press.

van Dyk, S. (2018). Post-wage politics and the rise of community capitalism. *Work, Employment and Society*, *32*(3), 528–545. https://doi.org/10.1177/0950017018755663

Wegleitner, K., & Schuchter, P. (2018). Caring communities as collective learning process: Findings and lessons learned from a participatory research project in Austria. *Annals of Palliative Medicine*, *7*(S2), S84–S98. https://doi.org/10.21037/apm.2018.03.05

Wegleitner, K., Schuchter, P., & Prieth, S. (2020). 'Ingredients' of a supportive web of caring relationships at the end of life: Findings from a community research project in Austria. *Sociology of Health & Illness*, *42*(5), 987–1000. https://doi.org/10.1111/1467-9566.12738

Wegleitner, K., Sprung, A., Kainradl, A.-C., Pupić, D., Kukovetz, B., & Kriebernegg, U. (2026). Social participation and active citizenship of older adults in caring neighbourhoods: Insights from the inter- and transdisciplinary project Caring-Living-Labs Graz. *Berliner Journal Für Soziologie*, *35*, 651–672. https://doi.org/10.1007/s11609-025-00585-0

Zentai, V. (2025). Political *uncommoning* through anti-gender mobilization by radical right-wing online voices. *Critique of Anthropology*, *45*(1), 84–95. https://doi.org/10.1177/0308275X251315277

About the Authors



Dóra Gábriel (PhD) is a sociologist and research fellow at the Centre for Economic and Regional Studies, ELTE, Hungary. Her main research interests are care marketization, the communitization of care, and international retirement migration.



Bettina Török is a sociologist and social gerontologist who worked for 17 years in the field of social institutions operated by civil society organizations. She is currently a PhD student at the University of Pécs, where her research focuses on the individual, community, and societal conditions of conscious aging. She is the CEO of the P-AGE Conscious Ageing Foundation.



Noémi Katona (PhD) is a sociologist and research fellow at the Centre for Social Sciences, ELTE, Hungary, and assistant professor at Corvinus University of Budapest. Her main research interests are gender, migration, care work, and sexual labor.

Social Inclusion
2026 • Volume 14 • Article 12028
https://doi.org/10.17645/si.12028

cogitatio

ARTICLE

Open Access Journal

Care Under Constraint: Unmet Care Needs Among Older Adults in Romania

Mihaela Hărăguș [1] and **Ionuț Földes** [2]

[1] Centre for Population Studies, Babeș-Bolyai University, Romania
[2] Department of Sociology, Babeș-Bolyai University, Romania

Correspondence: Mihaela Hărăguș (mihaela.haragus@ubbcluj.ro)

Submitted: 29 January 2026 **Accepted:** 20 April 2026 **Published:** 27 May 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Population ageing is a common trend across Europe, yet its social consequences vary significantly between countries. In Romania, older adults face heightened risks of social exclusion and vulnerability, shaped by the legacy of post-communist welfare transformations and large-scale emigration. The shift from a state-socialist model of social protection to a fragmented, residual system has led to a growing reliance on families and informal networks. At the same time, outmigration of the care workforce abroad has generated a domestic care drain. As a result, access to care in later life is characterised by significant inequalities, which depend on family resources, material conditions, and geographic location. Drawing on a 2025 national survey of over 900 persons aged 65 and older, this study examines the relationship between the care needs of older people and the support they receive, with the aim of identifying the most vulnerable groups. Anchored in the care poverty framework, the analysis considers individual characteristics (age, gender, health status, socioeconomic position), family context (living arrangements, presence of migrant children), and structural dimensions (urban-rural divides). Findings reveal that older adults living in rural areas, those residing alone, individuals with migrant close family members, weak social networks, material deprivation, or poor health are more likely to experience care poverty. These results highlight the uneven distribution of care resources and point to the urgent need for targeted policy interventions to mitigate inequalities in later-life care provision.

Keywords

care needs; care poverty; later-life inequalities; Romania

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Increased life expectancy and longevity have led to a steady growth in the share of older people across Europe, with those aged 65 and above accounting for approximately one-fifth of the total population (Eurostat, 2024). In 2024, 20% of Romania's population was over the age of 65. Although demographic ageing is a common European trend, its social consequences are not evenly distributed across the continent.

Following the collapse of the communist regime in 1989, Romania's transition to a market economy was among the most radical in the region, characterised by what Ban (2016) terms "disembedded neoliberalism," a form of market liberalisation marked by minimal social buffers and limited welfare investment. Over the past decades, the development of policy sectors has not followed a single, coherent pattern of change (Rațet al., 2019). The result is a dualised welfare system that offers relatively generous, contribution-based horizontal redistribution for those in stable employment but limited vertical redistribution for precarious workers and individuals with reduced market capacity (Rațet al., 2019), such as older persons. Social services for vulnerable groups, including long-term care for older persons, have largely remained the responsibility of families or have been outsourced to private organisations, often with limited state support (Rațet al., 2019).

In Romania, the obligation of a person's descendants to support their parents when they can no longer support themselves is stipulated in the Family Code; support may be in-kind or financial. State intervention is subsidiary and complementary, stepping in only when neither older adults nor their families can secure adequate housing and care. Consequently, public allowances for old-age care are low and unevenly accessible. As a result, families bear both the labour and a significant share of the financial costs associated with care. The reach of formal services remains limited, particularly in rural areas and for low-income households.

More recent policy documents emphasise the prevention of institutionalisation, the expansion of home care services, and the provision of support for family carers (Romanian Government, 2022). However, implementation has so far been partial. Recent legislative changes signal a cautious shift toward recognising informal care, notably through the introduction of a standard contract for informal carers and the regulation of care allowances (Ministry of Labour and Social Solidarity, 2023). While these measures aim to protect carers from labour-market withdrawal, in the absence of substantial investment in affordable home-based services, they risk formalising family care rather than expanding service coverage.

These institutional arrangements interact with enduring cultural norms that emphasise family responsibility and traditional gender roles in caregiving. Historical analyses show that Romanian family policy has been predominantly child-centred, prioritising demographic objectives over support for carers or the development of comprehensive long-term care systems for dependent adults (Inglot et al., 2022). As a result, care for dependent older persons has remained marginal within the family-policy framework, reinforcing reliance on informal, family-based care. Caregiving is commonly framed as a moral obligation, primarily assumed by women and frequently delivered without specialised training or adequate public support (Rațet & Szikra, 2018).

Taken together, these dynamics point beyond questions of service provision toward the relational foundations of care itself. We argue that care goes beyond a simple service transaction. Instead, it is a relational practice deeply embedded in social relationships. The availability or lack of care during times of

need serves as an indicator of an older person's embeddedness in supportive relationships and, more broadly, of their inclusion within or exclusion from essential social networks (Tronto, 1993). These dynamics are shaped by interconnected structural factors, including class, gender, and where one lives, which affect both the availability of care and the ability to access it. To better understand these inequalities, we employ the conceptual framework of care poverty (Kröger, 2022; Kröger et al., 2019). This concept sees unmet care needs not just as a lack of services, but as a result of broader social vulnerabilities. Care poverty includes both the lack of practical help and the weakening of relationships that usually support caregiving. Therefore, unmet care needs can indicate not only a need for assistance but also exposure to structural disadvantages and limited access to resources.

By foregrounding the interplay between relational care and structural limitations, this research contributes to a more complex understanding of how ageing, inequality, and the moral economies of care intersect in post-socialist contexts. Specifically, the study examines how care relationships are structured for non-institutionalised older adults and the extent to which their support needs are met or remain unmet. Although research on ageing and care has expanded significantly in recent decades, studies focusing on Central and Eastern Europe remain relatively limited, and those specifically addressing Romania are particularly scarce. Using data from a national survey on older persons aged 65 years and over, conducted in 2025, the article addresses two research questions:

> RQ1: How do structural and socio-economic conditions shape the likelihood that older adults experience unmet care needs in Romania?
>
> RQ2: How do relational and familial factors interact with health status in influencing whether older adults' care needs are met or remain unmet?

To analyse these dynamics, the article combines a care configuration perspective with the concept of care poverty, thereby understanding unmet care as both structurally and relationally produced. The next section reviews the relevant literature and develops the theoretical framework, focusing on the intersection between care configurations and care poverty. Six hypotheses are built around the role of individual characteristics (age, gender, health status, socioeconomic position), family context (living arrangements, presence of migrant children), and structural dimensions (urban-rural divides). The third section discusses the data and research methodology. The findings are then presented comparatively across different care outcomes (no need, met need, unmet need). The article concludes by discussing the implications of the findings for social inclusion policies and care provision practices.

2. Literature Review and Theoretical Framework

Drawing on the care configuration model (Daly, 2021; Pfau-Effinger, 2017; Williams, 2018), care practices are situated within a broader sociocultural and institutional context, emphasising how welfare regimes, gender norms, and family structures co-constitute specific constellations of care. In parallel, the concept of care poverty (Kröger, 2022; Kröger et al., 2019) provides an analytical lens through which unmet care (having care needs but not receiving adequate or any support) is interpreted not simply as a service deficit, but as a manifestation of material and relational deprivation under conditions of social vulnerability. By putting these perspectives into dialogue, our contribution challenges the reductionist view of care as a

technical or commodified service, instead advancing care as a socially embedded practice that is both shaped by and constitutive of broader structures of inequality, dependency, and social cohesion.

Starting from the premise that care is a complex social process embedded in the institutional and relational fabric of society (Tronto, 1993, 2013), care can also be understood as a right, a need, and a resource for social inclusion. It is not merely an act of support but a fundamental condition for social participation and dignity in old age. By integrating the care configuration and care poverty frameworks, we aim to explain the overlapping effects of macro-structural forces and micro-level relational dynamics on care. This nuanced analysis transcends the idea that care is an isolated flow of labour and highlights its incorporation within moral economies, welfare systems, and everyday support practices.

Neoliberalism, as described by Harvey (2005), does not function in opposition to local moral values but instead operates through their co-optation and re-signification, particularly by emphasising individual responsibility and familialism's ideals (Nguyen et al., 2017). Care for older people is produced within configurations of actors, resources, norms, and regulations that transcend the boundaries of the state, market, family, and the voluntary sector (Glucksmann & Lyon, 2006). From the perspective of "the total social organisation of labour," these domains are interdependent rather than separate. Care spans public and private divisions, as well as paid and unpaid sectors, and is enacted through ties of varying strength, continuity, and authority (Glucksmann & Lyon, 2006). Configurations are relational and contextual, reflecting who is available to care, under what conditions, with which skills, time, and money, and according to which normative expectations (Daly, 2021; Potter, 2019; Tronto, 2017). Potter (2019) revisits two contrasting models of care allocation: the task-specificity model, which focuses on the alignment between carers' capacities and care tasks, and the hierarchical-compensatory model, which assumes that care needs will be met sequentially by available members of a normative caregiving hierarchy. In this sense, configurations are the mechanisms that generate concrete support structures. The care poverty lens shifts our attention to the outcomes of these mechanisms, conceptualising unmet care needs as a form of deprivation and social exclusion rather than a mere individual shortfall (Kröger, 2022; Kröger et al., 2019). It insists that whether needs are met depends on structural arrangements such as welfare rules, financing, marketisation, and territorial service supply, as well as on gendered and familistic norms that allocate responsibilities.

We use care configurations to explain how support is organised, and care poverty is a diagnosis of failure within that structure. Care configurations specify the mix of actors, resources, and rules through which care is produced, and care poverty indicates when that mix does not suffice, leaving needs unmet. The resources at hand, their quality, and the governing regulations can transform needs into effective support or leave them unmet. The key distinction between the presence or absence of adequate support in the face of care needs becomes central for understanding which older adults are able to maintain their dignity, autonomy, and participation, and which are left with unmet needs, fragmented care, or complete neglect (Potter, 2019). Who is deemed "deserving" of support, and under what conditions, is not value-neutral (Daly, 2021). Care configurations, then, reflect not only resource distributions but also symbolic and normative judgements that include or exclude older adults from meaningful support networks. Drawing on research on poverty and inequality, especially the notion of deprivation as social exclusion, Kröger (2022) argues that inadequate care is comparable to being denied other essential social goods. In this view, care is not just a service or resource but a social right, and its absence constitutes care poverty.

Across Europe, older people have become increasingly likely to live alone in recent decades due to demographic factors (declining fertility has reduced the number of adult children with whom to share a household), economic factors (increased income levels enabled people to afford to live independently), and cultural factors (increased individualism; Dykstra, 2021, p. 206). Women are more likely than men to live alone due to their higher life expectancy and, consequently, their higher risk of becoming widows. Those living alone often turn to individuals outside their household for support when necessary. They are at risk of unmet care needs, especially as they age and their health declines (Calderón-Jaramillo & Zueras, 2023; Dykstra, 2021; Kröger, 2022; Vlachantoni, 2019). Considering the risks mentioned above, we expect that older adults living alone are more likely to experience unmet care needs than those living with a partner or other family members (H1). Building on this, another hypothesis posits that older adults with weaker support networks are more likely to experience unmet care needs than those embedded in stronger social networks (H2).

International and internal migration patterns influence the availability of carers, the conditions they must meet, and the resources they can access. These patterns influence care configurations, which can either prevent or produce care poverty. The out-migration of working-age adult children can increase the financial capacity of non-migrant older parents through remittances (Földes, 2020). This phenomenon can result in family care being replaced by purchased services or informal arrangements, but it can also leave gaps where service markets are weak or eligibility rules are stringent (Kilkey & Merla, 2014). At the same time, transnational and circular mobilities produce complex and diverse care relationships maintained not only through money, but also through visits and mediated communication, with moral expectations of reciprocity negotiated at a distance (Baldassar & Merla, 2014). In this sense, transnational family arrangements can serve as a compensatory measure for weak local support. Literature on transnationalism explains the connections between the family, state, market, and non-profit sector through the "care diamond" and shows how care tasks are concentrated within households (Vianello, 2016). Within these constellations, caregiving responsibilities are maintained by a person who remains in the country of origin, typically a woman from the extended family or an informal network. At the same time, migrant relatives provide financial remittances and coordinate support from afar. For the parents of migrants, however, access to public, commercial, or non-profit services remains intermittent and stratified along social lines, leading to an unequal distribution of care deficits (Vianello, 2016). Discussing care migration, Lutz and Palenga-Möllenbeck (2011) argue that destination countries externalise their social reproduction costs by relying on women from Central and Eastern Europe, whereas countries of origin experience a familial care deficit. Romania is one of the main countries of origin for care workers in Western Europe, resulting in a significant care drain effect. Accordingly, we expect that older people with close family members living abroad are more likely to experience unmet care needs (H3).

In a care configuration, gender, as a key normative determinant, describes who is expected to do what, when, and for whom. Within personal networks of significant others, ties differ by type and frequency, and their formation reflects life-course trajectories shaped by class stratification, gender differences, and generational position (Widmer, 2010; Widmer et al., 2018). Gender role inequalities are especially evident in familialistic regimes characterised by strong family obligation norms and limited formal care provision (Haberkern et al., 2015). Furthermore, gender inequality increases due to high public spending on cash benefits and low professional care (Haberkern et al., 2015). In familialistic settings, gender norms translate into the recurrent assignment of hands-on, time-intensive care to women (especially daughters or daughters-in-law; see Batur

et al., 2024; Raschick & Ingersoll-Dayton, 2004). Studies using SHARE data demonstrate that women are more likely to provide informal care and to do so as sole caregivers, while men tend to share or outsource caregiving responsibilities (Bertogg & Strauss, 2020; Ilinca et al., 2022). Women appear to be more likely to use both formal and informal support, whereas men primarily rely on informal care (Ilinca et al., 2022). In terms of care receipt, women are more likely to experience unmet healthcare needs than men due to economic reasons (Rahman et al., 2022). Building on this literature and given that Romania is characterised by limited formal care services and strong familistic norms, we expect that gender significantly influences access to adequate care, with women being more likely than men to experience unmet care needs (H4).

Research on the association between resource availability and the likelihood of experiencing unmet needs is inconsistent. For example, when controlling for age, health, or living arrangements, variables that described the care recipients' socio-economic status did not significantly account for unmet needs (Dunatchik et al., 2019; Hlebec et al., 2016). Other research shows that unmet healthcare needs are strongly linked to education level, primarily due to cost-related barriers (Rahman et al., 2022). Older adults with higher education levels report substantially lower cost-related unmet needs than those with lower education levels (Rahman et al., 2022). More substantial evidence suggests that the income group is a significant determinant of explaining unmet needs. Older adults without economic privileges are more likely to have unmet care needs than those who are rich, regardless of the reason for the lack of support (Rahman et al., 2022). Based on this evidence, we hypothesise that lower socio-economic status, as reflected in lower education and existing material deprivation, increases the likelihood of experiencing unmet care needs (H5).

Internal mobility and uneven territorial development also negatively affect access to care by placing services and paid carers in cities, creating "care deserts" in rural and peripheral areas, where transport barriers, shortages of skilled personnel, and service deficiencies make it difficult to meet care needs (Brînduşe et al., 2024; Ungureanu et al., 2020; Weinhold & Gurtner, 2014; World Bank, 2022). Higher-income regions tend to offer better-quality care, while increased mobility of patients and workers may exacerbate inequalities and undermine service stability in middle- and low-income areas (Brekke et al., 2016). Based on this, in the Romanian context, we expect that older adults living in rural areas are more likely than those in urban settings to experience unmet care needs (H6).

3. Methodology

3.1. Data

The data used in this study were collected through a nationally representative survey targeting the Romanian population aged 65 and over. The survey was implemented by a professional research company with extensive experience in social science fieldwork in Romania, the Romanian Institute for Evaluation and Strategy (https://ires.ro). The sample consists of individuals selected through a simple random sampling using random digit dialling (RDD). To ensure adequate coverage of the older population, the sample was supplemented with respondents from previous surveys who met the age criteria and had originally been selected through probabilistic methods. Data collection was conducted in January 2025 using computer-assisted telephone interviewing, a method that enhances the standardisation and reliability of responses.

The questionnaire was designed to capture multiple dimensions of older adults' lives and care arrangements, including self-reported physical health, emotional well-being, financial needs, sociodemographic characteristics, family migration (particularly the emigration of adult children), help received and provided, living arrangements, and attitudes towards long-term care and support. The questionnaire included "tried-and-tested" survey questions from existing recognised surveys measuring relevant concepts, such as the Survey on Health, Ageing and Retirement in Europe, the Generations and Gender Survey, and the Population Policy Acceptance Study, brought together to capture issues at the intersection of ageing, care, migration, intergenerational responsibility, and commodification.

All procedures complied with applicable national and European data protection requirements. Informed consent was obtained from all participants, personal data were pseudonymised prior to analysis, and data were stored securely for research purposes only. As the data were collected through a telephone survey, participation was necessarily limited to older persons able to engage independently in a phone interview. This implies that individuals with very severe impairments, such as advanced dementia or serious hearing problems, are likely underrepresented, and that observed levels of care needs and unmet care needs should be interpreted as conservative estimates. At the same time, the survey is well-suited to capturing the situations of older adults living in private households—who constitute most of the older population in Romania—and for whom care arrangements are most strongly shaped by family resources, social networks, and local service availability. In this sense, the data are appropriate for analysing how relational and structural factors intersect to produce unmet care needs outside institutional settings, which is the primary focus of this study.

Table 1 presents the composition of the analytical sample, consisting of 918 individuals. Unweighted frequencies reflect the observed sample distribution, while weighted percentages reflect the estimated population distribution after post-stratification weighting applied on age, sex, urban-rural residence, regional distribution, and education level. The most notable difference is in the education level. Likely due to the recruitment method, the analytical sample overrepresents highly educated individuals relative to the general old age Romanian population, which is characterised by comparatively low educational attainment.

Table 1. Sample composition.

Variable		N (unweighted)	% (weighted)
Gender	Man	408	39.9
	Woman	510	60.1
Education level	Low education	108	46.4
	Medium education	549	41.9
	High education	261	11.6
Age	65–74 years	673	61.6
	75+ years	245	38.4
Living arrangement	Living with spouse only	403	39.7
	Living alone	288	36.3
	Other living arrangement	227	24.0
Residence	Urban residence	543	53.9
	Rural residence	375	46.1

Table 1. (Cont.) Sample composition.

Variable		N (unweighted)	% (weighted)
Support network	Good support network	779	81.0
	Weak support network	139	19.0
Material deprivation	No material deprivation	668	65.1
	Material deprivation	250	34.9
Migration of family members	No migrant family member	624	62.4
	Migrant family member	294	37.6
Self-perceived health status	Good health	792	78.3
	Bad health	126	21.7

3.2. Method

The survey did not register detailed activities of daily living (ADL) but asked about any long-term illness or condition that might create difficulties in performing daily activities. We consider respondents with severe difficulties to have needs for care that are more intensive, similar to ADL (e.g., eating, bathing, walking). We are interested in seeing the match between the care needs and the support received and, consequently, the dependent variable accounts for three possible situations: no need for care (either no long-term illness or no limitation in performing daily activities), need for care and support received, and need for care but no support received.

In measuring unmet care needs, we adopt an absolute approach, as introduced by Vlachantoni (2019), which refers to individuals with a clear and identifiable need for care who do not receive any support. The downfall of this approach is that it portrays those who receive care as receiving the support they need, without accounting for the quality or adequacy of that care, thereby underestimating the prevalence of unmet care needs. Our focus will consequently be on the most vulnerable groups, those who are entirely excluded from care systems, whether formal or informal (Vlachantoni, 2019).

Several groups of explanatory factors are included in the analysis. One set consists of relational and familial factors, referring to support network opportunities and constraints: living arrangements, the existence of migrant family members, and the reported strength of the support network. We grouped living arrangements in three categories: living alone, living with a spouse only, and other configurations. The strength of the support network is dichotomous, measuring whether the respondent confirmed having enough people around them whom they could ask for help in any situation.

A second group of variables refers to structural and socio-economic conditions, such as rural or urban residence, material deprivation, and education level. For material deprivation, we followed the Eurostat methodology: A person is considered to experience household-level material deprivation if they lack at least three of the following items: capacity to face unexpected expenses, capacity to afford paying for one week of annual holiday away from home, capacity to be confronted with payment arrears (on mortgage or rental payments, utility bills, hire purchase instalments or other loan payments), capacity to afford a meal with meat, chicken, fish or a vegetarian equivalent every second day, ability to keep home adequately warm, access to a car/van for personal use, and ability to replace worn-out furniture. Education was grouped into

three levels: low (elementary), medium (secondary), and high (tertiary). The control variable age is grouped into two categories: 65–74 years and 75 and above. Self-perceived health status is grouped into two categories: poor health (those who rate it as bad or very bad) and not poor health (those who rate it as neither good nor bad).

Using multinomial logistic regression, we comparatively investigate the characteristics of older people associated with each of the three instances of the need-support combination: no need for care, needs with support, and needs without support. Our focus will be on the most vulnerable category of those with care needs but lacking support.

4. Descriptive Results

We consider reporting severe difficulties in performing daily activities to be equivalent to the need for personal care. By the same logic, we considered reporting at least moderate difficulties as being similar to having needs for practical help around the household, like the instrumental ADL (e.g., cleaning, cooking, shopping). The overall degree of perceived difficulties in daily activities is 22% for severe difficulties and 53% for at least moderate difficulties. However, the extent of difficulties varies by different characteristics. Individuals with self-perceived bad health show the highest degree of limitations in performing daily activities. Women, persons aged 75 and above, those with the least education, individuals living alone, those experiencing household-level material deprivation, those with a close family member who is a migrant, those with a weak support network, or those residing in rural settlements exhibit greater dependence on support (Figure 1).

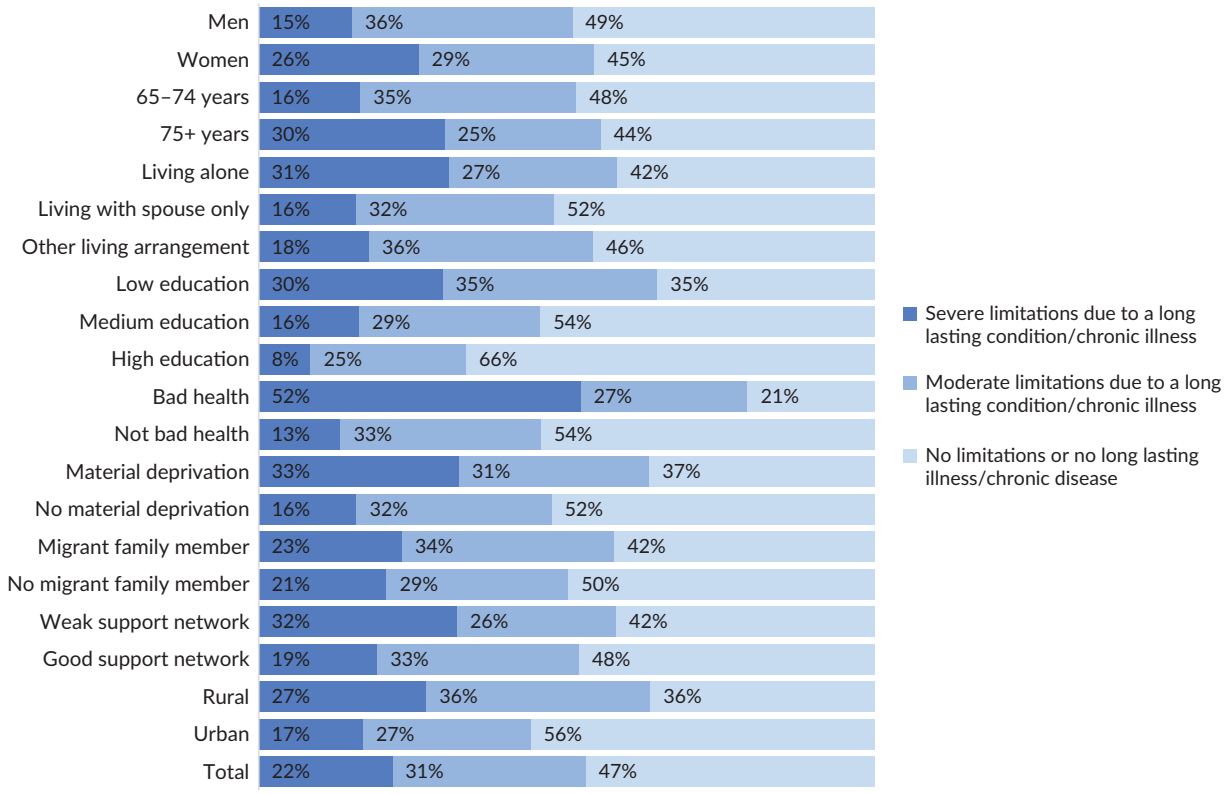


Figure 1. Distribution of respondents by the degree of limitations in daily activities and different characteristics. Note: The figure shows weighted percentages. Source: Authors' analysis based on primary data.

Further analysis reveals that those with severe limitations in daily activities (considered as having needs for personal care) disproportionately confront a lack of support (Figure 2). The overall level of care received, as a percentage of individuals in need who receive help, is only 19%. Only for the oldest, in poor health, those with family members in their proximity (not living alone or not having close migrant family members), or living in urban settlements, does the level of help and care they receive exceed 20%.

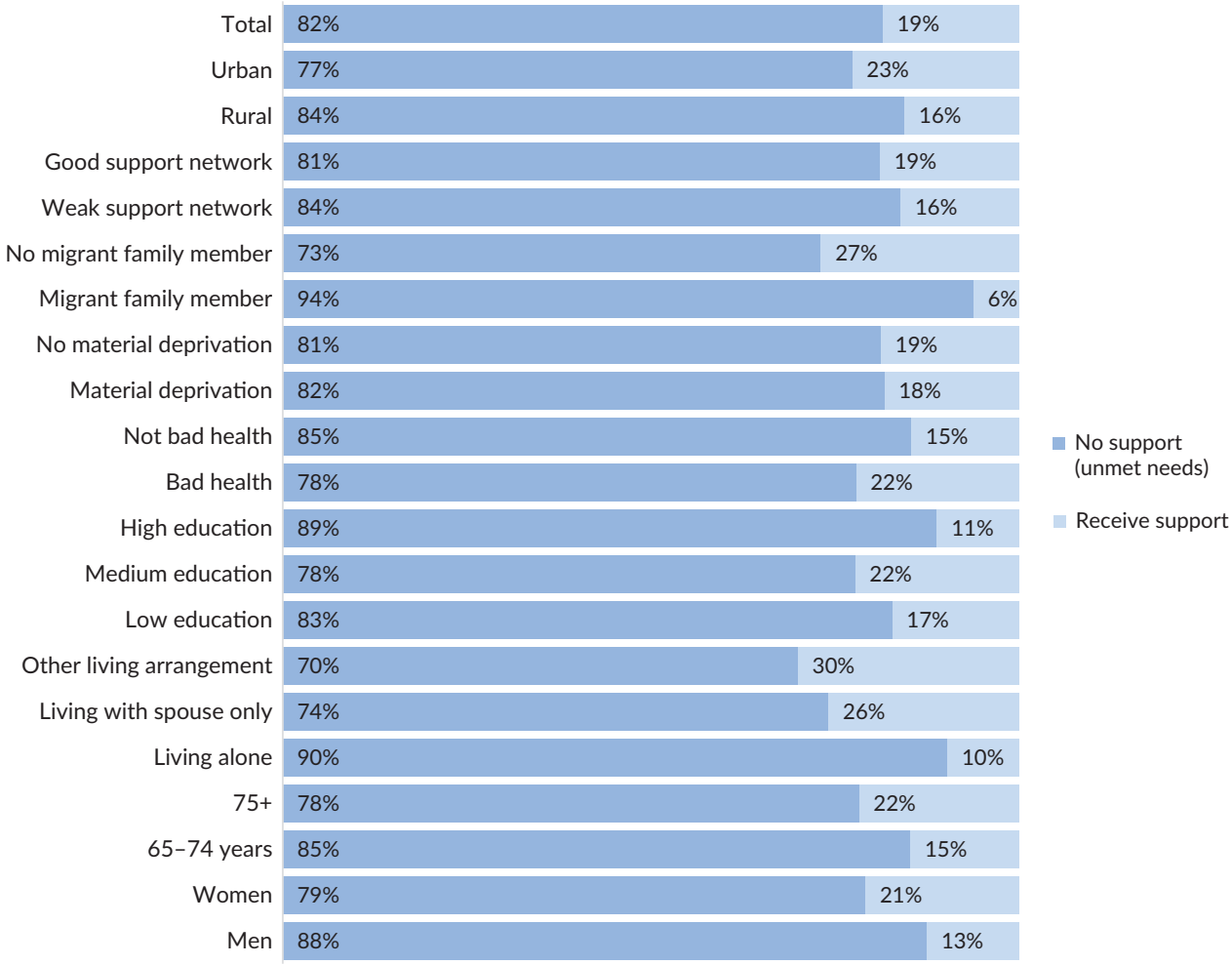


Figure 2. Respondents with severe limitations in daily activities, organized by support received and different characteristics. Note: The figure shows weighted percentages. Source: Authors' analysis based on primary data.

By considering the presence or absence of personal care needs alongside the availability or lack of support and care, we gain an in-depth understanding of older individuals. We use this approach in our multivariate analysis to compare the characteristics of respondents associated with each outcome and to profile the most vulnerable group of persons with unmet care needs. Figure 3 illustrates that within the entire sample, the most vulnerable individuals—characterised by unmet care needs—are women, the oldest, those living alone, individuals with low educational attainment, those in poor health, those facing material deprivation, individuals with a migrant family member, those with a weak support network, and residents of rural areas.

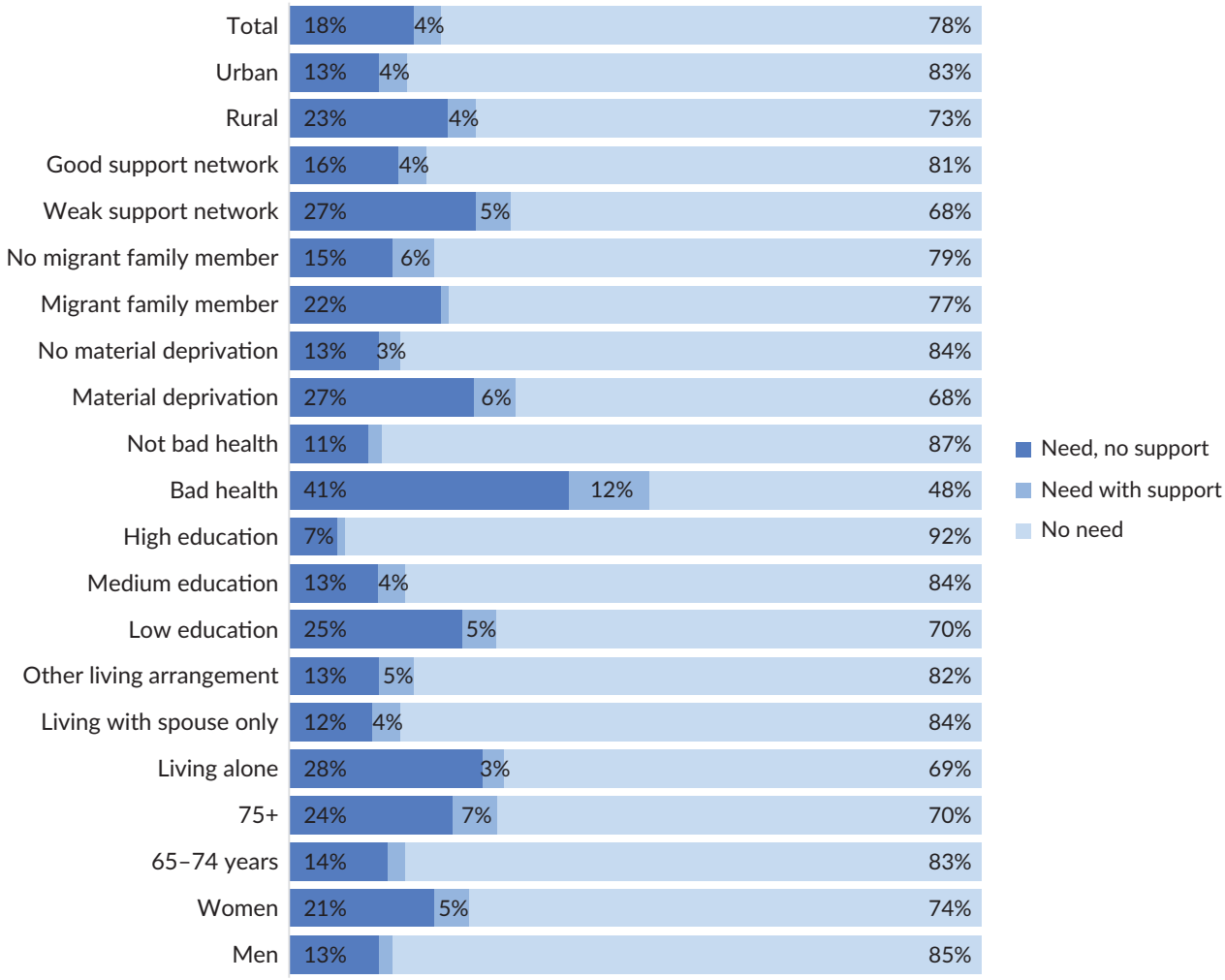


Figure 3. Distribution of respondents by personal care needs, support received, and various individual and structural characteristics. Note: The figure shows weighted percentages. Source: Authors' analysis based on primary data.

5. Multivariate Analysis

We performed a multinomial logistic regression to explore the factors associated with care needs and the likelihood of receiving support. These results are interpreted as associational rather than causal effects. The results of the model are presented in Table 2, which reports the average marginal effects (AMEs) for each outcome across categories of the independent variables. Since all independent variables are categorical, these marginal effects represent the difference in predicted probability between each category and the reference category, averaged across all observations. The dependent variable captures the relationship between the existence of personal care needs and the availability of support. It distinguishes between three possible outcomes: (a) no need for (personal) care, referring to individuals with no severe limitations in daily activities; (b) need with support, representing individuals reporting severe limitations in daily activities who receive support; and (c) need without support, referring to individuals experiencing severe limitations and unmet care needs.

Among all predictors included in the model, self-reported health shows the strongest associations with care needs. Poor health is significantly associated with a higher likelihood of reporting a need for care, whether met or unmet, compared to good health (AME = 0.218 [0.147, 0.288] and AME = 0.113 [0.060, 0.167], respectively). The higher predicted probabilities of unmet care needs among individuals with difficult health conditions highlight a critical gap between the recognition of care needs and the availability of effective support systems. Since health status operates as the strongest and most predictable determinant of care needs, this result also validates the internal consistency of our model.

Table 2. Results of multinomial logistic regression (marginal effects): Personal care needs vs. care received.

Variable	No need			Need, support			Need, no support		
	AME	90% CI		AME	90% CI		AME	90% CI	
		LL	UL		LL	UL		LL	UL
Man	0.023	−0.016	0.061	−0.001	−0.019	0.017	−0.021	−0.058	0.015
Woman (ref)									
Low education	−0.065	−0.130	0.001	0.022	−0.005	0.050	0.042	−0.020	0.105
Medium education	−0.047*	−0.091	−0.003	0.02*	0.003	0.037	0.027	−0.016	0.070
Higher education (ref)									
65–74 years (ref)									
75+ years	−0.01*	−0.031	0.052	0.011	−0.031	0.008	−0.001	−0.039	0.040
Living with spouse only (ref)									
Living alone	−0.041	−0.085	0.003	−0.007	−0.027	0.012	0.048*	0.006	0.091
Other living arrangements	−0.016	−0.062	0.029	0.001	−0.022	0.024	0.015	−0.028	0.059
Urban residence (ref)									
Rural residence	−0.031	−0.069	0.007	−0.017	−0.034	0.000	0.048**	0.011	0.085
Good support network (ref)									
Weak support network	−0.069**	−0.123	−0.015	0.015	−0.010	0.039	0.054*	0.002	0.106
No material deprivation (ref)									
Material deprivation	−0.043*	−0.086	0.000	0.001	−0.017	0.019	0.042*	0.001	0.083
No migrant family member (ref)									
Migrant family member	−0.036	−0.075	0.004	−0.009	−0.026	0.008	0.045*	0.007	0.083
Good health (ref)									
Bad health	−0.331***	−0.409	−0.253	0.113***	0.060	0.167	0.218***	0.147	0.288

Note: * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$; AME = average marginal effects, LL = lower limit, UL = upper limit. Source: Authors' own survey data; analysis by the authors.

Living arrangements and the migration of family members are relevant factors in predicting unmet needs. Living alone is associated with a 4.8 percentage-point higher predicted probability of reporting unmet needs (AME = 0.048 [0.006, 0.091]) compared with persons living with a spouse only, while having a migrant family member is associated with a 4.5 percentage-point higher predicted probability of unmet needs (AME = 0.045 [0.007, 0.083]). Although both effects are marginally significant, our regression model thus provides evidence for hypotheses H1 and H3. Moreover, the weak support networks category is associated with a higher predicted probability of unmet needs, supporting H2 (AME = 0.054 [0.002, 0.106]), and with a lower probability of remaining in the no-need group (AME = −0.069 [−0.123, −0.015]). The association between living alone, weak support networks, and migrant family members, on the one hand, and higher probabilities of unmet care needs, on the other, reflects limited access to care rather than the absence of family solidarity.

Gender shows no statistically significant effect on unmet care needs in any of the three outcome categories (Table 2), suggesting that, in the Romanian context, men and women do not differ significantly in their likelihood of experiencing unmet needs. This leads to the rejection of H4. This absence of gender effect might suggest that broader structural and economic inequalities absorb gender differences, consistent with prior research indicating that gender disparities in unmet needs become pronounced when financial limitations are the principal obstacle to obtaining support (Rahman et al., 2022).

Structural and socio-economic factors, such as material conditions, type of residence, and level of education, are stronger predictors of both care needs and access to care (Table 2). Older adults experiencing material deprivation show a predicted probability of unmet care needs that is 4.2 percentage points higher (AME = 0.042 [0.001, 0.083]) than that of those without severe financial difficulties, confirming H5. Material deprivation and medium education are also associated with a lower probability of reporting no need (AME = −0.043 [−0.086, 0.000] and AME = −0.047 [−0.091, −0.003], respectively), suggesting that socio-economic advantage reduces not only exposure to unmet needs but also the risk of developing functional limitations that require support. Similarly, older adults residing in rural areas show a predicted probability of unmet needs that is 4.8 percentage points higher (AME = 0.048 [0.011, 0.085]) than that of those residing in urban areas, confirming H6 about territorial and socioeconomic differences in access to care.

6. Discussions

This study examined the relationship between the care needs of older people and the support they receive, aiming to identify how structural, relational, and individual factors contribute to care poverty. We addressed this issue using data from a recent nationally representative survey of persons aged 65+. Using a multinomial logistic regression model, we examined three care outcomes—no need, met need, and unmet need—and tested six hypotheses derived from an integrated care configuration and care poverty framework.

Our findings are consistent with other research, which shows that the link between specific characteristics of individuals and unmet needs for care transcends country-specific policy contexts (Vlachantoni, 2019). Our results emphasise, however, the specificities of familialistic regimes that, heavily relying on close family members, encompass the greatest volume of unmet needs (Kröger, 2022). For the specific case of Romania, the migration of family members and living in rural areas are additional vulnerabilities that reflect both

fragile care configurations and systemic exclusions that result in care poverty. These findings show that unmet care needs do not result solely from individual frailty but from patterned exclusions tied to both care availability and social embeddedness (Kröger et al., 2019; Tronto, 1993).

A key finding was that poor health increases the probability of experiencing care poverty. As Kröger (2022) argues, such an effect is expected but not self-evident. Health status certainly affects the level of care needed, but it doesn't always determine the extent of unmet needs, particularly when individuals who require assistance can receive it. The occurrence of unmet needs in people with health problems isn't unavoidable; it indicates a failure in how care is organised, whether it's provided by family or through formal systems (Kröger, 2022). This breakdown is especially clear in Romania, where formal long-term care services are limited and families are expected to provide care. In this context, the availability of economic and material resources influences the ability to adequately meet health-related care needs. In line with this interpretation, our results show that education level is not a significant predictor of unmet care needs, whereas material deprivation emerges as a robust predictor. Kröger's (2022) interpretation, which links care poverty more closely to material and economic constraints than to educational differences, aligns with these findings.

Gender and age were not statistically significant predictors of unmet care needs. Our findings may indicate the extent to which gendered expectations are ingrained in household care relations. Women may seem imperceptible in models that insufficiently describe intra-household negotiations and ethical responsibilities (Tronto, 1993; Widmer et al., 2018). Our descriptive analyses nevertheless indicate that women and the oldest-old exhibit higher levels of unmet care needs. However, multivariate analyses demonstrate that living alone, more common among the oldest-old females, is a significant predictor. This means that in our analysis, the observed gender and age disparities function indirectly through living arrangements rather than as independent factors.

Living alone is associated with weak or fragmented care configurations, characterised by the absence of coresident carers and, therefore, reliance on alternative care networks such as non-coresident adult children, neighbours, relatives, or formal services. These networks may be inconsistent or unable to adequately respond to intensive care duties. In Romania's familialistic-by-default regime, living alone constitutes a structural disadvantage because personal care infrastructure requires physical proximity to family members. This reliance on family-based care is reflected in our results. We showed that the migration of close relatives increases the risk of unmet personal care needs among older adults. The migration of children, especially daughters, may disrupt the traditional care configuration and leave older adults without their primary carers. Because personal care is provided on a co-presence basis, high rates of emigration and limited public care provision put many older adults at risk of being excluded from both family and formal care. These findings align with literature on care drain, in which the out-migration of potential carers, especially women, creates local care deficits that are difficult to compensate through either remittances or fragmented informal networks (Földes, 2020; Lutz & Palenga-Möllenbeck, 2011).

When access to formal services is limited and institutional care is not preferred, the availability of an informal support network remains crucial. We have shown that a weak support network increases the probability of unmet care needs. In a familialistic regime such as Romania, non-coresident family members, neighbours, and friends compensate for the absence of a coresident carer. The increased likelihood of unmet

personal care needs among older people living alone and those with migrant family members can be interpreted as the outcome of intersecting relational vulnerabilities and structural disadvantages. Our integrated framework argues that the inability to meet needs is not an individual failure. Getting needs met depends on social relationships, is shaped by social structures, and is often ignored by care systems that expect informal, gendered, and live-in carers to be available. The study shows that these groups are especially vulnerable to care poverty due to micro-level caregiving failures and macro-level exclusions, necessitating both relational and policy interventions. Just as income poverty triggers targeted redistribution and housing deprivation activates housing policy, care poverty should activate responses across the long-term care, social services, and public health domains.

One limitation of our study arises from the quantitative approach we used. Our sample omits the most vulnerable older people, including those with dementia, significant frailty, or those who are institutionalised. This omission reflects a broader gap in care research, where the perspectives and experiences of the most dependent older adults remain systematically underrepresented (Vlachantoni et al., 2011). Future studies should prioritise the inclusion of these groups, as their experiences of unmet need are likely more acute and may follow different patterns than those captured here.

7. Conclusion

Our findings bring together and build on earlier evidence about unmet care needs, showing how different care outcomes are linked to various structural, relational, and individual factors. While previous studies emphasised similar predictors of unmet needs, our results integrate these factors into a comparative framework that simultaneously distinguishes among older people without care needs, those with met needs, and those lacking support for their needs. Older persons without care needs represent a privileged group. They are in good health, have higher education, are not materially deprived, and enjoy being part of broader social networks. Despite the unknown adequacy of the care they receive, older adults experiencing their needs being met typically have poor health and are less educated. Finally, the most disadvantaged category is the older adults with unmet care needs. Specifically, this category captures multiple vulnerabilities at the individual level (poor health, material deprivation), the relational level (living alone, transnational family dispersion, and weak social networks), and the structural level (rural residence). These findings stress that layered vulnerabilities are clearly linked to care outcomes.

Theoretically, the study contributes by combining the care configuration approach with the concept of care poverty, thereby offering a novel analytical framework for understanding social inclusion in later life. This dual lens allows for a relational and structurally embedded perspective on care, focused on both personal networks and broader institutional constraints. Romania is presented as a critical case for examining broader regional trends, such as reliance on familial care and the limited reach of formal welfare systems. The insights developed here resonate with patterns observed across Central and Eastern Europe while also informing global debates on ageing, vulnerability, and inclusive care policies.

Addressing care poverty in the Romanian context requires policy responses that must move toward integrated social and territorial approaches, tackling both care and inequality. Investment in care infrastructure in disadvantaged and rural areas is a necessary starting point, while community-based models that build relational capital—including neighbourhood care networks, volunteer visiting schemes, and peer

support for isolated older adults—may be relevant policy responses. Subsidised formal care and means-tested home help programmes should be developed to complement or replace family care, treating material deprivation as a barrier to accessing care rather than as a separate welfare concern.

To conclude, this study advances existing research on unmet care needs by empirically mapping a full spectrum of care outcomes—no need, met need, and unmet need—within a single multinomial framework. Our results show that unmet need emerges from the convergence of individual frailty, material deprivation, fragile social networks, and rural disadvantage, thereby extending earlier evidence to include spatial and relational dimensions. As a policy implication, care poverty is not a peripheral welfare concern but a structural dimension of social inequality that governments should measure, monitor, and reduce.

Acknowledgments

This article was produced as part of the project "Researching the Transnational Organization of Senior Care, Labour and Mobility in Central and Eastern Europe" (CareOrg, 2023–2026; https://careorg.eu), funded by the Volkswagen Foundation within the programme "Challenges and Potentials for Europe." Both authors have contributed equally to the article.

Funding

Publication of this article in open access was made possible through the institutional membership agreement between Babeș-Bolyai University and Cogitatio Press.

Conflict of Interests

The authors declare no conflict of interests.

Data Availability

The data is not available for public use.

LLMs Disclosure

ChatGPT was used for rephrasing, style improvement, and proofreading.

References

Baldassar, L., & Merla, L. (Eds.). (2014). *Transnational families, migration and the circulation of care: Understanding mobility and absence in family life*. Routledge.

Ban, C. (2016). *Ruling ideas: How global neoliberalism goes local*. Oxford University Press.

Batur, Z. Z., Vergauwen, J., & Mortelmans, D. (2024). The effects of adult children's gender composition on the care type and care network of ageing parents. *Ageing and Society*, *44*(1), 17–42. https://doi.org/10.1017/S0144686X21001999

Bertogg, A., & Strauss, S. (2020). Spousal care-giving arrangements in Europe. The role of gender, socio-economic status and the welfare state. *Ageing and Society*, *40*(4), 735–758. https://doi.org/10.1017/S0144686X18001320

Brekke, K. R., Levaggi, R., Siciliani, L., & Straume, O. R. (2016). Patient mobility and health care quality when regions and patients differ in income. *Journal of Health Economics*, *50*, 372–387. https://doi.org/10.1016/j.jhealeco.2016.05.003

Brînduşe, L., Eclemea, I., Neculau, A., Păunescu, B. A., Bratu, E. C., & Cucu, M. A. (2024). Rural versus

urban healthcare through the lens of health behaviors and access to primary care: A post-hoc analysis of the Romanian health evaluation survey. *BMC Health Services Research*, *24*, Article 1341. https://doi.org/10.1186/s12913-024-11861-9

Calderón-Jaramillo, M., & Zueras, P. (2023). Cared and uncared populations: Understanding unmet care needs of older adults (65+) across different social care systems in Europe. *European Journal of Ageing*, *20*, Article 11. https://doi.org/10.1007/s10433-023-00760-3

Daly, M. (2021). The concept of care: Insights, challenges and research avenues in COVID-19 times. *Journal of European Social Policy*, *31*(1), 108–118. https://doi.org/10.1177/0958928720973923

Dunatchik, A., Icardi, R., & Blake, M. (2019). Predicting unmet need for social care. *Journal of Long-term Care*, *2019*, 194–205. https://doi.org/10.31389/jltc.33

Dykstra, P. A. (2021). Living arrangements in later life. In N. F. Schneider & M. Kreyenfeld (Eds.), *Research handbook on the sociology of the family* (pp. 205–217). Edward Elgar Publishing. https://doi.org/10.4337/9781788975544.00021

Eurostat. (2024). *Population structure and ageing. Statistics Explained*. European Commission. https://ec.europa.eu/eurostat/statistics-explained/index.php?oldid=661901

Földes, I. (2020). Linked lives across borders: Economic remittances to ageing parents in Romania. *Comparative Population Studies*, *45*, 65–85. https://doi.org/10.12765/CPoS-2020-03

Glucksmann, M., & Lyon, D. (2006). Configurations of care work: Paid and unpaid elder care in Italy and the Netherlands. *Sociological Research Online*, *11*(2), 25–39. https://doi.org/10.5153/sro.1398

Haberkern, K., Schmid, T., & Szydlik, M. (2015). Gender differences in intergenerational care in European welfare states. *Ageing and Society*, *35*(2), 298–320. https://doi.org/10.1017/S0144686X13000639

Harvey, D. (2005). *A brief history of neoliberalism*. Oxford University Press.

Hlebec, V., Srakar, A., & Majcen, B. (2016). Determinants of unmet needs among Slovenian old population. *Slovenian Journal of Public Health*, *55*(1), 78–85. https://doi.org/10.1515/sjph-2016-0011

Ilinca, S., Rodrigues, R., Fors, S., Zólyomi, E., Jull, J., Rehnberg, J., Vafaei, A., & Phillips, S. P. (2022). Gender differences in access to community-based care: A longitudinal analysis of widowhood and living arrangements. *European Journal of Ageing*, *19*(19), 1339–1350. https://doi.org/10.1007/s10433-022-00717-y

Inglot, T., Szikra, D., & Raț, C. (2022). *Mothers, families or children? Family policy in Poland, Hungary, and Romania, 1945–2020*. University of Pittsburgh Press.

Kilkey, M., & Merla, L. (2014). Situating transnational families' care-giving arrangements: The role of institutional contexts. *Global Networks*, *14*(2), 210–229. https://doi.org/10.1111/glob.12034

Kröger, T. (2022). *Care poverty: When older people's needs remain unmet*. Springer International Publishing. https://doi.org/10.1007/978-3-030-97243-1

Kröger, T., Puthenparambil, J. M., & Van Aerschot, L. (2019). Care poverty: Unmet care needs in a Nordic welfare state. *International Journal of Care and Caring*, *3*(4), 485–500. https://doi.org/10.1332/239788219X15641291564296

Lutz, H., & Palenga-Möllenbeck, E. (2011). Care, gender and migration: Towards a theory of transnational domestic work migration in Europe. *Journal of Contemporary European Studies*, *19*(3), 349–364. https://doi.org/10.1080/14782804.2011.610605

Ministry of Labour and Social Solidarity. (2023). Order No. 955 of 19 April 2023 approving the standard contract concluded between the informal caregiver of a dependent older person and the public social assistance service. *Official Gazette of Romania*, *544*.

Nguyen, M. T. N., Zavoretti, R., & Tronto, J. C. (2017). Beyond the global care chain: Boundaries, institutions

and ethics of care. *Ethics and Social Welfare*, *11*(3), 199–212. https://doi.org/10.1080/17496535.2017.1300308

Pfau-Effinger, B. (2017). The development of welfare state policies towards care work within and outside the family. In P. Kennett & N. Lendvai-Bainton (Eds.), *Handbook of European social policy* (pp. 231–246). Edward Elgar Publishing. https://doi.org/10.4337/9781783476459.00029

Potter, A. J. (2019). Care configurations and unmet care needs in older men and women. *Journal of Applied Gerontology*, *38*(10), 1351–1370. https://doi.org/10.1177/0733464817733239

Rahman, M. M., Rosenberg, M., Flores, G., Parsell, N., Akter, S., Alam, M. A., Rahman, M. M., & Edejer, T. (2022). A systematic review and meta-analysis of unmet needs for healthcare and long-term care among older people. *Health Economics Review*, *12*, Article 60. https://doi.org/10.1186/s13561-022-00398-4

Raschick, M., & Ingersoll-Dayton, B. (2004). The costs and rewards of caregiving among aging spouses and adult children. *Family Relations*, *53*(3), 317–325. https://doi.org/10.1111/j.0022-2445.2004.0008.x

Raț, C., Popescu, L., & Ivan, V. (2019). The Romanian welfare system: From the shadow of equality to the dazzle of dualisation. In S. Blum, J. Kuhlmann, & K. Schubert (Eds.), *Routledge handbook of European welfare systems* (2nd ed., pp. 425–443). Routledge. https://doi.org/10.4324/9780429290510-25

Raț, C., & Szikra, D. (2018). Family policies and social inequalities in Central and Eastern Europe: A comparative analysis of Hungary, Poland and Romania between 2005 and 2015. In J. G. Eydal & T. D. Rostgaard (Eds.), *Handbook of family policy* (pp. 223–235). Edward Elgar Publishing.

Romanian Government. (2022). National strategy on long-term care and active ageing for 2023–2030. *Official Gazette of Romania*, *1251*.

Tronto, J. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.

Tronto, J. (2013). *Caring democracy: Markets, equality, and justice*. New York University Press.

Tronto, J. (2017). There is an alternative: Homines curans and the limits of neoliberalism. *International Journal of Care and Caring*, *1*(1), 27–43. https://doi.org/10.1332/239788217X14866281687583

Ungureanu, M.I., Brînzac, M. G., Forray, A., Paina, L., Avram, L., Crișan, D. A., & Donca, V. (2020). The geriatric workforce in Romania: The need to improve data and management. *European Journal of Public Health*, *30*(Suppl. 4), iv28–iv31. https://doi.org/10.1093/eurpub/ckaa127

Vianello, F. A. (2016). International migrations and the reaorganization of care: The case of Moldova, Romania and Ukraine. *Migraciones*, *38*, 61–86. https://doi.org/10.14422/mig.i38.y2015.003

Vlachantoni, A. (2019). Unmet need for social care among older people. *Ageing and Society*, *39*(4), 657–684. https://doi.org/10.1017/S0144686X17001118

Vlachantoni, A., Shaw, R., Willis, R., Evandrou, M., Falkingham, J., & Luff, R. (2011). Measuring unmet need for social care amongst older people. *Population Trends*, *145*(1), 60–76. https://doi.org/10.1057/pt.2011.17

Weinhold, I., & Gurtner, S. (2014). *Understanding shortages of sufficient health care in rural areas*. *Health Policy*, *118*(2), 201–214. https://doi.org/10.1016/j.healthpol.2014.07.018

Widmer, E. D. (2010). *Family configurations: A structural approach to family diversity*. Ashgate; Routledge.

Widmer, E. D., Gouveia, R., Aeby, G., & Česnuitytė, V. (2018). Understanding personal networks as social capital. In K. Wall, E. Widmer, J. Gauthier, V. Česnuitytė, & R. Gouveia (Eds.), *Families and personal networks—Palgrave Macmillan studies in family and intimate life* (pp. 167–186). Palgrave Macmillan. https://doi.org/10.1057/978-1-349-95263-2_6

Williams, F. (2018). Intersectionality, gender and social policy. In S. Shaver (Ed.), *Handbook on gender and social policy* (pp. 37–54). Edward Elgar Publishing. https://doi.org/10.4337/9781785367168.00008

World Bank. (2022). *Romania's way forward in long-term care*.

About the Authors



Mihaela Hărăguș (PhD) is a researcher at the Centre for Population Studies, Babeș-Bolyai University in Cluj-Napoca, Romania. Her research interests include intergenerational relations in families in general, and in transnational families in particular, as well as the challenges of population ageing for the development of long-term care.



Ionuț Földes (PhD) is a lecturer in demography, statistics, and family sociology at the Faculty of Sociology and Social Work, Babeș-Bolyai University in Cluj-Napoca. His research interests include demography and population sociology, social inequalities in ageing and care, intergenerational relationships, family dynamics, implications of migration for well-being, and support across generations.

Social Inclusion
2026 • Volume 14 • Article 12029
https://doi.org/10.17645/si.12029

cogitatio

ARTICLE

Open Access Journal

Skill Construction and Challenges of Professionalization in the Hungarian Home Care Market

Noémi Katona [1,2] **and Dóra Gábriel** [1,3]

[1] ELTE Centre for Social Sciences, Hungary
[2] Corvinus University of Budapest, Hungary
[3] ELTE Centre for Economic and Regional Studies, Hungary

Correspondence: Noémi Katona (katona.noemi@tk.elte.hu / noemi.katona@uni-corvinus.hu)

Submitted: 29 January 2026 **Accepted:** 26 May 2026 **Published:** 13 July 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Precarious working conditions, low pay, and limited access to labor and social rights characterize market-based home care globally. Alongside growing concerns about the exploitation of carers, calls for the professionalization of the sector have also intensified. However, qualifications and training in market-based care services remain only loosely regulated. Drawing on Ortiga et al.'s (2021) concept of skill regimes and the literature on skills and professionalism in care, this article examines how a segmented informal care market shapes the construction of skills considered necessary for providing good care, and to what extent training initiatives support professionalization. The analysis is based on qualitative interviews with care workers, family members, intermediaries, and training providers, as well as ethnographic fieldwork conducted through online and in-person training programs. The findings show that the strong underregulation of the home care market has hindered the emergence of widely accepted professional standards, while similarly underregulated training programs often fail to support professional competency development and instead undermine the value of formal qualifications. The Hungarian case thus illustrates how a loosely regulated skill regime can contribute to both deprofessionalization and market segmentation.

Keywords

care marketization; home-based care; professionalization of care; skills regime; tacit knowledge

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Demographic aging and the increasing care needs of older people are among the major challenges that European societies face today. In most countries, older people typically prioritize home care over residential care (Bartha & Zentai, 2020). However, since states are not keeping up with the growing demand for home care services, care for older people is both familiarized and commodified in many European countries. In recent decades, market-based home care has become an essential pillar of long-term care in most European countries.

Although the home care market constitutes a crucial component of care systems, it is typically undervalued in most countries, marked by precarious working conditions, low remuneration, and limited or absent access to social and labor rights (Aulenbacher et al., 2021, 2024; Palenga-Möllenbeck, 2022). These challenges have intensified debates around service quality and the professionalization of care work. However, training and qualification requirements associated with market-based home care remain weakly regulated in many contexts (Fiebig-Spindler, 2026; Wojczewski et al., 2023). Consequently, the meaning and implementation of professionalization in home care require further investigation.

Care has historically been framed as a "natural" feminine attribute rather than recognized as skilled and professional labor. Feminist scholars have long criticized the systematic undervaluation of care and other forms of reproductive labor (Lutz, 2011), drawing attention to the persistent lack of social, economic, and institutional recognition attached to this work. Recognizing care as professional labor has become increasingly important in international policy frameworks, including several ILO conventions, which provide an important basis for strengthening labor rights and improving working conditions in the care sector. Nonetheless, the meaning of professionalism in care for older people remains highly contested. Debates continue over what kinds of knowledge, competences, and emotional capacities constitute professional care work, and to what extent care skills can or should be standardized. In the scholarly literature, there are numerous approaches to the professionalization of care for older people. These address working conditions, regulations, standards, and remuneration, but also, very importantly, the required skills, competencies, behaviors, and practices of care workers. The state, through regulation and policy, plays a central role in shaping and institutionalizing professional care. This relates to what Ortiga et al. (2021) conceptualize as an "elderly care skills regime comprising a loose configuration of policies, programmes and institutions that govern what constitutes appropriate skills for elderly care and who can be suitably equipped to perform such tasks" (p. 437). While Ortiga et al. primarily examine skills regimes at the intersection of care and migration regimes, they also provide a feasible framework for studying how skills are governed and constructed in a national context, allowing us to examine processes of (de)professionalization.

This article examines the Hungarian skills regime in the home care market for older people. Thereby, it pays attention to how professionalism is constructed in the narratives of various stakeholders within the sector and to which kinds of skills are emphasized. Additionally, the article investigates market-based training programs for home care workers, focusing on their assessment by different stakeholders. Specifically, the study explores: (a) which skills and knowledge are constructed in the narratives of care workers, family members, and intermediaries when talking about "good care"; (b) what kind of qualifications matter, and how much; and (c) what skills does market-based training aim to develop, and how far do these contribute to the professionalization of care services. The analysis draws on qualitative data from interviews with care

workers, family members, intermediaries, and training providers, as well as ethnographic fieldwork involving participation in both online and in-person training sessions.

In the investigated Hungarian case marketization of home care remains largely informal, underregulated, and highly segmented. In this context, a parallel market of training and "skilling" has emerged, shaped primarily by private actors with minimal state oversight. The article argues that this has important consequences for both the quality of care and the construction of professionalism in home care. By linking stakeholders' narratives on skills to the structure and segmentation of the care market, the analysis highlights how care provision operates in an open market where even intermediation is frequently organized through social media, without meaningful institutional regulation or oversight. In doing so, the article applies and further develops the concept of skill regimes by studying and connecting regulation, the training system, market segmentation, and narratives on skills in care, including professionalization and personalization trends and the discourse on care quality.

2. Knowledge, Skills, and Professionalism in the Home Care Sector

Professionalization in care for older people has been approached differently in the international literature. What skills and knowledge are necessary to provide professional care, and whether they can be measured and standardized, have been widely debated and analyzed. Many scholars draw on Polanyi's (1966) concept of tacit knowledge as a central element of professional care for older adults, understood as subjective, embodied knowledge that cannot be fully articulated verbally. Based on participant observation in care units in Sweden, Börjesson et al. (2014) studied the importance of "silent knowledge," or tacit knowledge, in the everyday work of care workers and highlighted the gap between this tacit, experience-based knowledge and the state policies' rather theoretical approach to knowledge in care. Similarly, Gottfried (2022) criticized the US care system for failing to recognize tacit knowledge in care for older people adequately and argued that this is an essential factor in the low wages and undervaluation of care. Reinders (2010) also criticized the aim of standardization and quantification, as well as methods of quality assessment that rely on objectively measurable "indicators," and sharply contrasted these with the crucial element of tacit knowledge in care, which also entails the know-how involved in building a personal relationship with care recipients. Kontos and Naglie (2009) also elaborate on tacit knowledge in care, highlighting the socio-cultural significance of embodied selfhood.

While some studies seek to define the core characteristics of professionalism in care, often contrasting tacit with rather fact-based knowledge, others offer more nuanced analyses of how professionalism is socially and institutionally constructed across different contexts and by various actors. Gazzaroli et al. (2020) examined how care workers in Italy construct their professional identities and demonstrated that the professional profile of home care workers remains poorly defined. Their findings show that carers' narratives about their skills and expertise are often vague and fragmented. While "hard" care skills were more frequently emphasized, these often overlapped with competencies found in other professions, whereas relational and "soft" skills tended to remain implicit and taken for granted.

The distinct skills and values involved in professional care—including both measurable, standardized hard skills and the soft skills required for relational, embodied, and emotional labor—have been widely discussed

in policymaking and policy analysis within the UK context as well. Hussein and Kispeter (2025) focus on care policies and their effects in the UK, and contrast "professionalization" to "personalization":

> Personalisation prioritises coproduction between care practitioners and those receiving support, aiming to empower individuals by granting them greater control over their care. In contrast, professionalisation focuses on the expertise of care workers, as reflected in formal qualifications and training, which may inadvertently prioritise professional credentials over care's relational and value-driven aspects. (Hussein & Kispeter, 2025, p. 10)

Hussein and Kispeter (2025) provide a detailed comparative analysis of policy approaches across the four nations of the UK, examining how the agendas of professionalization and personalization intersect and sometimes conflict. Hayes et al. (2019) also analyze how these policy aims are implemented across the same four nations and the skills they require. In addition to medical knowledge and "values of care," they also list communication, digital, employability, and body-work skills. However, in the UK context, where care services have been increasingly outsourced to the market for several decades, Hemmings et al. (2022) highlight the diversity and complexity of care provision systems, showing that different groups of care workers rely on distinct skill sets. All in all, the UK context shows a complex and rather regulated home care market, in which local governments shape local markets in different ways, promoting the efficient operation of market services to meet care needs (Needham et al., 2023).

Marketization is a crucial trend in the development of care regimes and, consequently, strongly shapes the skills regime and how skills in care work are constructed. In Germany, while national legal regulations define carers' qualifications in the public sector, the authorities responsible for setting and enforcing such standards in the home care market are far less clearly defined (Grenz & von Kutzleben, 2024). This regulatory ambiguity results in weak oversight of qualifications and, consequently, low levels of formal training among live-in carers. In Austria, for example, live-in care workers do not require any formal training to be able to work (Wojczewski et al., 2023), and there are no legally defined qualifications for live-in carers in Germany either (Fiebig-Spindler, 2026). The lack of regulation has a crucial effect on how skills are defined in care work. Giordano (2021) compares professionalization in private and public care in Belgium and argues that, while formal qualifications are more important in public care, market actors focus more on emotional labor, soft skills, and vocation when interpreting professionalization. The discourse of market actors (i.e., brokering agencies) that highlight soft skills can result in the work of migrant carers being naturalized, essentialized, and even perceived as nationally embedded characteristics rather than learned professional competences (Palenga-Möllenbeck, 2022). Social hierarchies and gendered and ethnicized expectations also play a fundamental role in the training of care workers and in the constructed subjectivities of "good carers" (Prieler, 2021).

Overall, the international literature highlights the tension between efforts to "professionalize" care work through standardization and the emphasis on measurable "hard skills" (e.g., medical knowledge), and approaches that foreground the "personal" dimensions of care, including emotional, intimate, and relational labor, also associated with tacit knowledge. Combining these two dimensions poses significant challenges both at the policy level and in everyday care practices. In our analysis, we contribute to this debate by examining how different actors narrate and understand skills associated with care work. This discourse and the lack of policies reflecting these aims are also crucial elements of the Hungarian skills regime that connects regulation, discourses, and working conditions in the home care market.

3. The Hungarian Care Regime and Its Implications for the Home Care Market

Since 2010, the Orbán regime in Hungary has restructured welfare politics in line with the broader political-economic model of illiberalism (Szikra & Öktem, 2023). While childcare was a prominent and well-funded issue under the Orbán regime (Fodor, 2022), care for older people was largely silenced in political discourse and severely underfunded (Katona & Gábriel, 2026). While the conditions of education and health care frequently feature in public discourse, issues related to social care, particularly care for older people, receive comparatively little attention. The increasing gap in care for older people resulting from labor shortages and the limited capacities of residential and home care services is striking, given the evidence. The social care sector in Hungary ranks among the lowest-paid fields, with particularly acute challenges in long-term care for older adults (Gyarmati, 2019, 2022; Meleg, 2025). Working conditions in the formal long-term-care sector are deplorable: Wages for care workers often fall below the already modest averages across the social services. This is especially problematic since the actual work of home carers requires more competencies than before, due to rising care needs. In terms of care activities performed by care workers over recent decades, while in the 1990s, social care involved shopping and cleaning, by the early 2020s, home-based care workers considered medical knowledge, symptom identification, and proper techniques for moving bedridden patients to be fundamental professional competencies (Vida, 2021). As care needs evolve, care workers must acquire new competencies and knowledge; however, they are not adequately compensated for these increased demands.

Due to the limited capacity of public care services, there is an increasing demand for market-based services, especially home care. Many workers in the formal social and health care sectors move to the market sector due to the difficult working conditions described above. However, the home care market is largely underregulated and informal. The Long-Term Care Strategy released in 2020 by the Ministry of Human Capacities (Emberi Erőforrások Minisztériuma, 2020) has been sharply criticized for lacking both a critical approach to the real problems and a clarification of the responsibilities of the actors involved in care, in particular the state (Gyarmati et al., 2021). While the Strategy fails to mention the existence of market-based home care, the more recent long-term-care strategy of 2024 also omits the informal market from the report (Belügyminisztérium, 2024). The employment of care workers is irregular due to the lack of a formalized home care market; however, the document's silence on the care market implies that the state has no intention of regulating the current situation.

As a result, the Hungarian home care market is strongly informal. Gábriel and Katona (2024) have analyzed the structure of the home care market, showing that different types of intermediaries provide various levels of protection and quality assurance to care workers and families. At the bottom are informal networks and social media-based online platforms, where carers and families connect directly with almost no formal regulation, contracts, or social protection, while at the top are agencies that provide formal employment for carers, which are very rare. In contrast to the trends of marketization in care known in Western European countries, characterized by the formalization of home care and large and powerful agencies (Aulenbacher et al., 2021), or more recent trends of the emergence of care platforms (Bonifacio & Pais, 2025), in Hungary informality prevails, and instead of the development of care platforms, social media groups unassociated with regulations are prevalent. All in all, due to the lack of regulation regarding who can provide home care services in the market (especially through social media), an extremely diverse pool of people advertise themselves on these sites.

This has crucial consequences for the lack of regulation of skills. While professional standards are regulated in public care provision, policy documents do not specify standards of practice or the required skills for market-based home care workers. This trend impedes effective regulation of the sector, leading to the absence of professional standards and oversight and, consequently, a decline in the overall quality of care (Katona & Gábriel, 2026). Crucial transformations in the training of care workers also contribute to this picture. The most significant changes include the decline of secondary schools specialized in medical and social care since the 2000s, and the accelerated spread of online training, especially since the Covid-19 pandemic in 2020. While institutions that provide such training should be officially licensed, the certificates of completion issued after these courses merely confirm that a person has participated and do not constitute officially recognized professional qualifications. They are issued directly by the training provider and do not require corresponding state-issued qualifications; therefore, there is weak state oversight of what is taught and how on these training courses.

The article will examine how relevant actors construct and negotiate discourses around care skills, and how participants evaluate the role and importance of training and formal qualifications.

4. Methodology

This study is part of a larger qualitative research project on the marketization of home care in Hungary, which has been underway since 2022. The current article builds on (a) semi-structured interviews with care workers, family members, intermediaries, and trainers; and (b) ethnographic research conducted during two training sessions.

4.1. Data Collection and Sample

The current article primarily relies on semi-structured interviews with care workers, family members of care recipients, and intermediaries, including companies that organize training sessions (Table 1). Interviews were conducted between 2022 and 2025, online or in person, in Budapest. Participants were recruited via official

Table 1. Interviewed stakeholders.

Stakeholder	No. interviews	Description
Intermediaries and training companies	8	Five formal intermediaries, including matchmaking companies (one providing training to their carers), one informal intermediary who uses her informal network to connect families and care workers, and two training companies that also offered matchmaking services.
Care workers, including social media group administrators	10	This sample also includes three social media group administrators, two of whom were qualified nurses with several years of experience working in hospitals; the third administrator was a qualified social carer. Of the other carers, three were qualified social carers, one was a qualified nurse, one had completed short-term training at a faith-based organization, and two had no training at all. Only one carer in the sample was male.
Family members	10	Family members were recruited through social media groups. The sample includes children, husbands, and grandchildren of (former) care recipients.

websites (in the case of matchmaking and training companies) and via social media groups focusing on home care services for older people. Preliminary mapping was also conducted during our research; we identified that Facebook is an increasingly important site for mediation in home care. The online mapping was conducted in 2025, and over 30 Facebook groups were identified (public and private) with over 1,000 members (ranging between ca. 1,000 and ca. 30,000) focusing on care for older people in Hungary, without any regional focus within the country. The names of most groups contained the words *gondozó* (carer) and *ápoló* (nurse). The groups were mainly founded in the 2020s, with some in the 2010s. We posted a call for research participation several times across seven Facebook groups where both family members and care workers are present. Additionally, we contacted the administrators of these Facebook groups directly to gather their perspectives and experiences. Throughout the article, we refer to carers who have completed a state-recognized professional qualification in nursing or social care as "qualified nurses" or "qualified carers."

Interviews explored experiences of home care work and mediation, focusing particularly on working conditions; perceptions of care skills and perceptions of qualifications. Agencies were asked about their own training requirements and programs, and social media group administrators were asked about their experiences as administrators. Training companies were specifically asked about the training content and the skills they taught.

The second component of the data collection effort consisted of participant observation conducted in 2025 at two different training providers. Given the limited empirical scope of the observations (only two training programs were attended), the aim was not to provide a comprehensive overview of existing training courses, but rather to illustrate and complement the narratives identified in the interviews. The two sites were selected to capture different forms of training provision: one in-person, and one online. The in-person training was chosen based on earlier interviews that identified the provider as a well-known actor in the field, while the online training was selected following an online mapping of available courses conducted in early 2025. This was conducted using the Google search engine, with combinations of the following keywords: "care," "caregiving," "senior care," "training," "training course," "education," and "online course." From the available training programs, we included only market-based ones for which participants paid a fee that were organized by a for-profit company. We distinguished two categories: (a) adult education platforms that include care training among many other courses, and (b) the websites of companies exclusively providing care courses, or closely related training. Finally, we interviewed a representative from a company in the first category and selected a training session from the second category to observe and gain insights from both types.

The on-site training course lasted five days and took place at a Budapest-based company with a strong reputation and high-quality instruction, as reported to us beforehand. Besides providing training, the company also engages in matchmaking activities. This on-site course was completed by author Dóra Gábriel. The second training program was completed by author Noémi Katona. This involved a 220-hour online course, which corresponded to the most common length of training identified during the desk research, and specialized exclusively in care-related training programs, such as babysitting and elderly care. During the participant observation, we collected ethnographic notes and documented observations. In both cases, we revealed our dual motivation—personal and academic—and clearly communicated the research purpose of our participation to the training organizer and fellow students. A research information and consent form outlining the study's objectives was shared with each company in advance.

4.2. Limitations, Potential Bias, and Positionality

As the research described in this article examined only two training programs and draws on a limited number of interviews, it cannot provide representative data or a comprehensive picture of the level and types of training across the Hungarian home care market; nonetheless, it offers important insights. Indeed, precisely because the home care sector is underregulated, there is a lack of reliable data on the level and types of training received by home carers. Another limitation of this study is that most interviews were conducted in the capital. Further research is needed in smaller municipalities, where the availability of home-based care provision may differ. Since participants were recruited through Facebook groups, the sample consisted of individuals who voluntarily chose to respond and share their experiences. This likely introduced a bias toward more engaged and dedicated carers and family members, while less committed or unreliable carers, frequently mentioned by interviewees, were probably underrepresented. Throughout the research process, we explicitly presented ourselves as researchers and clarified the study's academic purpose to all participants. We had no prior personal or professional relationships with the individuals or organizations involved in the research, which helped us maintain an independent position during data collection and analysis.

4.3. Data Analysis

All interviews were audio-recorded and transcribed verbatim using Alrite software, after which the transcripts were reviewed and corrected by the authors. Afterward, inductive thematic analysis following Braun and Clarke (2006) was applied to the interview material using MAXQDA software. The analysis focused on participants' narratives of skills, care practices, carers' duties, and the assessment of formal qualifications. Thematic analysis enabled the identification and interpretation of recurring patterns and meanings across participants' accounts. Interviewing different stakeholder groups also enabled reflection on the diverse positions from which this discourse was constructed. Ethnographic notes and the educational materials from the training sessions that were attended were also analyzed using the same methodology.

4.4. Research Ethics

At the beginning of the research project, in 2022, all methods that were applied were approved by the ethics committee of ELTE Centre for Social Sciences. For both online and offline interviews, participants were provided with information about the study's objectives, and all interviewees subsequently signed a consent form outlining their rights and data management procedures. They were informed that they could withdraw their consent, or decline to answer specific questions. Participants also agreed to the use of interview excerpts once any sensitive data had been anonymized. Throughout the article, we use acronyms to refer to our respondents: CW for care worker, FM for family member, MC for matchmaking company, SMA for social media administrator, TC for training company.

5. Personalization Versus Professionalization in the Home Care Market

In our empirical fieldwork, we encountered a wide range of narratives about what constitutes good care in market-based home care for older adults. In the following sections, we will analyze how interviewees perceive the role of hard skills (e.g., medical knowledge) and soft skills (e.g., empathy and tacit knowledge), depending on their background; and how far these narratives support aims of professionalization versus

personalization. Subsequently, we will examine how different stakeholders evaluate the role of qualifications and, finally, analyze the skills that the observed training programs were designed to develop.

As discussed previously, personalization and professionalization are described in the literature as two distinct, often conflicting trends and aims. While personalization focuses on the relational aspect of care and the needs and control of the care recipient, professionalization "includes initiatives such as registration and professional regulation, compulsory training, continuous professional development, career progression, and minimum employment standards" (Hussein & Kispeter, 2025, p. 5). Both approaches appeared in the interview narratives; however, nearly all stakeholders emphasized the central importance of personal relationships in care, while narratives resembling professionalization were considerably less frequent.

It was primarily qualified nurses who articulated that fact-based knowledge, training, and continuous professional development are necessary to provide care:

> But this profession is one [for which] you must keep learning all the time….You always learn something, because there are new techniques, new things, healthcare is developing….And the problem here is that experience is not necessarily good experience—the way you do it might not actually be right. (CW08)

The quoted care worker specifically questioned the legitimacy of relying solely on personal, on-the-job experience when this is not supported by formal training in care work. A representative of a training company expressed a very similar opinion, emphasizing the importance of formal qualifications and professional training in care work. She stressed that experience gained in a family setting does not in itself qualify a person to be a professional caregiver:

> It's not certain that someone who has cared for their own mother is suitable to be a professional caregiver….Through our training, we aim to ensure that caregivers can perform their job safely and competently. (TC02)

These narratives construct professionalism on the basis of the possession of fact-based knowledge and qualifications, and acknowledge tacit knowledge and experience only if acquired in professional training settings. However, as mentioned, these accounts were relatively rare. A matchmaking company explicitly mentioned that the introduction of compulsory training would not work: "If I told a carer, 'Fine, but before you come work for me you have to complete some training,' they might immediately run away. And that is not in my interest" (MC05). A family member stated explicitly that they do not consider care to be a profession that requires extensive training:

> If someone decides that they want to be a carer, I don't think they need very much. You don't need to be a nurse or a very qualified person, but a two-week training course, I think…would be good. (FM02)

Instead, most narratives highlighted the relational aspects of care and framed these as the most important elements of their work. "So, I have to get under their skin [to know them intimately], because if I don't, it doesn't work" (CW05), as a care worker noted. Family members, carers, and intermediaries all emphasized the role of "sympathy" in the care relationship. As one carer, a trained nurse, noted:

> But I think the most important thing in the world is to find a common tone [have a harmonious relationship]. If a caregiver cannot find the right way to communicate with the person they care for, and vice versa, then there is nothing to talk about—in that case, they should leave. So, the first impression and mutual sympathy are extremely important. (CW09)

When discussing what good care means, beyond the relational aspects, interviewees highlighted various skills and types of knowledge, including empathy and psychological skills. A qualified nurse also addressed the importance of psychological knowledge, but immediately referred to qualification and fact-based knowledge:

> A good caregiver is someone who has empathy, who truly sees the patient in their vulnerable situation, who has proper qualifications, and who knows that it matters how you move the patient, how you speak to them, or what you give them to eat. (CW08)

In her narrative, the ability to "see the patient" was therefore also linked to formal qualifications. When discussing psychological knowledge and skills, many stakeholders referred to care recipients living with dementia, which appeared to be highly prevalent among care users. In these cases, references to empathy often reflected the need to understand the specific characteristics of the disease and to respond to them appropriately. Thus, while the literature often distinguishes communication skills and medical knowledge (Hayes et al., 2019), some interviewees described these as closely intertwined in caring for people living with dementia.

In other narratives, empathy and soft skills were more closely associated with personal qualities and attitudes than with acquired psychological knowledge. This was especially common among carers without training:

> This cannot be learned. It simply cannot be learned. A person is either born with it [or not]—it's their life purpose, their calling. (CW09)

The quoted carer expressed an essentialized view that personality and natural skills in care work are superior to both factual and tacit knowledge and qualifications. According to this approach, the relevance of formal qualifications and fact-based knowledge must be questioned. This position was in line with the narratives of family members, who seldom considered professional qualifications essential in caring relations. Family members tended to prioritize dedication and personal traits, such as mutual sympathy and compatibility, and the significance of formal training did not emerge in their narratives:

> She [a carer] became absolutely dear to our hearts—she kept praying constantly for my mother-in-law. She could have listened to the radio, watched TV,…whatever, but instead, she chose to sit there and pray. (FM03)

All in all, the importance of trust and care in personal relationships prevailed in the narratives. It was also considered consequential whether carers could be replaced by others: "It cannot be that my mother sees a different face here every day" (FM04). In some cases, this was the reason families decided to purchase a market-based service instead of relying on the public home care they had received, as in their view private providers were better able to ensure continuity of carers, whereas frequent staff turnover in public home care was beyond their control. All matchmaking companies explained that when they select an eligible carer for a

family, they consider not only the skills required for the tasks but also the personalities of the carer and the care recipient: "We always try to work in a way that is adapted to the patient's needs" (MC08).

While the literature on personalization mainly emphasizes the needs and autonomy of care recipients (Hussein & Kispeter, 2025), which is the prevailing narrative of market actors (Giordano, 2021), the narratives in our sample show that care workers also considered it important for their own job satisfaction to be able to choose whom they care for, based on personal compatibility with the care recipient and their family: "I would say it also matters what kind of home you enter and whom you let into your home. It works both ways" (CW06).

6. Contested Professional Standards in a Segmented Market

Besides dedication, reliability and trustworthiness were among the most frequently emphasized qualities across all stakeholder narratives. These can be understood as forms of "employability skills" (Hayes et al., 2019), referring to the ability to perform care work responsibly. Social media group administrators, who possessed a broader overview of this segment of the home care market, mostly complained about the low professional standards they had encountered from many other carers, and described cases of neglect or maltreatment:

> Yes, there were cases—and more than one—involving incorrect medication practices, alcoholism, taking sedatives, not showing up for work, and abandoning the patient. (SMA02)

These narratives pointed not only to a lack of medical knowledge but also to problematic attitudes toward both the work and the care recipients, including inappropriate communication. Administrators had even experienced instances of illiteracy that prevented carers from writing down basic information about patients in their own language: "I have even met a carer who could not write her own name" (MC04). In other cases, a lack of basic knowledge of hygiene-related issues was complained about.

Thus, many care workers and administrators of social media groups reported a continuous decline in the quality of care and often quoted a saying about the home care market: "You get what you pay for." By this, they meant the poor quality of work produced by colleagues who lack the skills, training, and knowledge to provide decent care work. Overall, the interviews reveal a segmented market, with significant differences in the quality of care.

While this narrative was represented by qualified carers working in Budapest, one of our informants working in the countryside, a qualified nurse, complained about families' lack of recognition of carers' qualifications and professionalism:

> The problem is that families don't really pay attention to it. So, if they like you as a person, they will accept you. So, they don't really care what your qualifications are….They don't have time to care about what is really good for that old person. (CW02)

In her view, families' ignorance and lack of attention to older people's well-being lead to low expectations and a generally lower quality of care. She claimed that even skilled professional carers (or nurses) cannot earn significantly more in the home-based care sector than unskilled workers. This divergent perspective, which

contrasts with accounts from other professional nurses, may indicate regional heterogeneity in the home care market.

The poor care quality was also reported in other segments of the market mediated by agencies. A matchmaking company owner explained that the problem of inadequate knowledge and skills is not new, even among formally qualified carers:

> There was a period [about 10–15 years ago] when I would only consider hiring a social care worker after checking where they had obtained their qualification. Some of them…who came in were absolutely dreadful. And yet, they had the official qualification. (MC07)

Social media administrators and qualified nurses were especially critical of online training and its use in providing care, and several interviewees claimed that it was "worth nothing":

> I would ban it, especially the online version. They [course attendants] have no practical experience, no qualifications, no knowledge—nothing. They don't even know the most basic things. (SMA02)

Some matchmaking companies are dedicated to providing high-quality care services and, to ensure quality, regularly organize training sessions for care workers. The company we interviewed aimed to ensure high-quality care by providing regular, mandatory training for its workers. They found this particularly important because, in their view, the official qualification may not accurately reflect the carer's professionalism: "The CV is unnecessary. In most cases, there is no professional background behind it" (MC03). This narrative reinforces the lack of trust in formal qualifications.

Although some companies claim to be dedicated to providing high-quality services, neither training nor matchmaking companies take responsibility for the work of carers, as their services are performed informally, without contracts between the company and the care recipient or the carer. Some family members also expressed the view that intermediaries should determine which care recipients require a qualified carer to prevent dangerous situations arising from unprofessional work by unqualified carers, such as medication-related errors: "I think that the intermediaries should be aware of who has what skills in this area….I think that whoever is the intermediary should be aware of exactly what the tasks are" (FM01).

However, some family members reported mixed or negative experiences with matchmaking companies and therefore returned to using social media groups. Interviewees recruited through these groups explained that, although they would prefer greater quality assurance from intermediaries, they could not afford the additional costs. These financial constraints—closely linked to the lack of state support—also limit the profitability of matchmaking services in Hungary (see also Gábriel & Katona, 2024). Therefore, social media sites, offering almost no quality assurance, have become key platforms for connecting the demand and supply sides of home care, linking family members with care workers (Palenga-Möllenbeck et al., 2026). The social media administrators we interviewed appeared motivated to contribute to quality assurance within the sector by voluntarily dedicating one to two hours of unpaid work daily to managing and moderating these groups:

> Well, this takes about two hours out of my life every day. So in the morning I go through the group, during the day I just briefly check in, and then usually I spend another hour on it in the evening. (SMA03)

Despite efforts to exclude carers and family members who fail to communicate or act in a dignified manner with each other and the care recipients or do not respect the assumed basic standards of care relationships, the absence of effective regulation and the limited demand for professionalism from either side have contributed to a decline in the overall quality of care services.

7. Market-Based On-Site and Online Training

Given the expanding market for short-term courses on home care and dementia care, we were curious whether the growing number of training opportunities might signal a process of professionalization, or whether they complicate the picture of skill construction in care. In the following section, we highlight our impressions after attending an online and an on-site training course.

The on-site training event took place over five days in a central district of Budapest. Each day, one or two trainers conducted the sessions, representing a diverse range of professional backgrounds. Among them were a pastoral carer, a nurse, a paramedic, a marketing expert, and a Catholic priest. One of the most significant contributions of the on-site course was its interactivity, allowing participants to ask the trainers questions. Questions and discussions addressed care workers' rights and working conditions, but communication skills and psychological knowledge (e.g., how to handle people living with dementia), and self-marketing skills were also addressed.

The training company's philosophy of good care emphasizes, first of all, humility and the vocation of care workers. As the head of the company said during a training session: "One must be humble toward the profession." However, the training focused more directly on everyday tasks and emerging issues related to caregiving. One of the most practical parts of the training was first-aid education. In addition, discussions about the identification and treatment of illnesses showed that the training placed strong emphasis on the transfer of fact-based, medical knowledge. Interestingly, the participants' questions tended to focus on everyday practical concerns, such as the proper protocol in specific situations or what would happen if the caregiver became ill.

Additionally, considerable attention was also paid to the company's internal regulations. The trainers emphasized the policy associated with their matchmaking activity. Matchmaking had to take place exclusively through them, as part of quality assurance. The exam consisted of open-ended questions to be answered at home and delivered on paper to the company. The questions covered the whole curriculum and were relevant to daily care work activities. After passing the exam, participants could receive a job offer from the company if they were seeking employment. Practical placement in a care home was missing from the curriculum, although it had been part of the program in earlier years.

The online course was advertised as a 220-hour training program and highlighted that this duration would be stated on the certificate, which was common practice for companies offering online training. However, in fact, the course material could be completed within a few days, and the final exam—consisting exclusively of multiple-choice questions—required only minimal effort to pass. There were no real-time sessions, lecturers, or experts to discuss the topics with, but the educational material was available online, and students were supposed to study on their own. In fact, it was more of a self-study course, without having the opportunity to ask questions about either factual material or everyday dilemmas. The video materials, which were strongly

advertised as an advantage of the training, were home-made-style videos in which (possibly) an employee of the training company sat at her computer and read the training material.

The training material was highly uneven in its terminology, relevance, and overall quality, combining very different levels of knowledge and skills. It began with basic household tasks, such as using a coffee machine, but later shifted abruptly to sections on diseases and gerontology written in highly medicalized language. These clinical sections appeared to have been copied from websites or medical textbooks and were often difficult to understand without formal medical training. The material also contained repeated passages and inconsistencies, suggesting that it had not been specifically adapted to the needs of home care workers. Although communication and general employability skills were addressed, the lack of practical training meant that tacit knowledge and concrete communication practices were largely absent from the curriculum.

All in all, despite their differences, participants received very similar certificates at the end of the two training programs. The on-site training—despite the short duration—did deliver an idea of what good care means, focusing primarily on humility, as the preferred attitude in care, and on the relational aspects of the latter, while also providing practical information relevant to everyday care tasks. By contrast, the online training addressed the relational aspects of care much less, instead providing guidance, or "fact-based knowledge," about everyday household duties, but also medical knowledge. Still, the overall low quality of the online training raised concerns about the adequacy of knowledge transfer and the company's credibility. This type of training not only misleads participants but also contributes to the broader devaluation of caregiving as a profession.

8. Discussion and Conclusion

This article has examined the construction of skills in the Hungarian home care market, situating the findings within broader debates on the marketization of care. Drawing on the conceptualization of Ortiga et al. (2021), who argue that the skills regime is governed, negotiated, and unevenly recognized through policies, markets, and discourses, the analysis demonstrated that the underregulation of the market and the explicit familialization of care for older adults have contributed to the absence of clear professional standards, leaving both training provision and quality assurance largely in the hands of market and informal actors. Additionally, the chronic underfunding of care for older people and the limited state support available to families have created a highly segmented market in which social media has become a dominant—and free—means of connecting families and care workers. As a result, these arrangements operate without quality assurance or the capacity to establish professional standards.

Based on Giordano's (2021) findings, a formal diploma or care-related training does not necessarily confer an advantage in the care market or lead to more professionalized work. Our empirical findings confirm this insight by revealing that notions of good care and professionalism are highly fragmented. A striking difference in how interviewees constructed skills lay in the extent to which they addressed the specific needs of the patients that had to be covered. Even though the personalization of care services (Hussein & Kispeter, 2025) was favored by all interviewees, intermediaries and qualified carers provided a more nuanced understanding of patients' needs and who should care for them, while carers without training and family members did not reflect on these specificities.

The aims of professionalization, focusing on qualification and fact-based knowledge, were much less present, while soft skills and tacit knowledge were seen as more important (Giordano, 2021). Additionally, most families valued personality and vocation. This divergence reflects the weak institutionalization of care work and the persistence of cultural understandings of care as women's "natural" disposition rather than as a skilled profession. This difference also reflects how the home care market operates. In cases when formal or informal intermediaries were involved, they could provide more personalized service, reflecting actual care needs. However, the segment of the home care market organized through social media groups provided the lowest level of quality assurance for care recipients and their families (Gábriel & Katona, 2024), as reflected in how carers' skills were evaluated. In the absence of intermediaries, families themselves had to decide what qualifications and skills were necessary and choose among available carers. Respondents to advertisements ranged from experienced nurses to individuals with no prior care experience, requiring families to invest considerable time and effort into assessing both competencies and costs. At the same time, many families were already overwhelmed and financially constrained, as the costs of home care often stretched the limits of affordability.

Short-term market-based training initiatives—which have prevailed in recent years—do not compensate for this trend. Instead of fostering the accumulation of professional skills and fact-based or tacit knowledge, short-term, often unregulated courses risk degrading the meaning of such qualifications, eroding rather than strengthening the idea that care work is a profession. The proliferation of such programs, together with the informal and underregulated operation of matchmaking services, perpetuates unequal access to quality care and market segmentation by quality, and further hinders market-wide quality assurance.

From a broader perspective, Hungary's home care system exemplifies a skills regime in which an informal home care market prevails, and the state outsources skill formation and quality assurance to private actors with insufficient oversight. This arrangement not only undermines the prospects for the professionalization of care work but also jeopardizes the long-term sustainability and quality of care for older people.

Acknowledgments

We thank the reviewers and editors for their feedback and comments. We are also grateful to our informants for sharing their insights with us. We would like to thank our colleagues in the CareOrg team for their feedback, support, and the collaborative work we have shared over the past years.

Funding

The project Researching the Transnational Organization of Senior Care, Labour and Mobility in Central and Eastern Europe (CareOrg, 2023–2026; https://careorg.eu) is funded by the Volkswagen Foundation (VolkswagenStiftung).

Conflict of Interests

The authors declare no conflicts of interests. In this article, editorial decisions were undertaken by Ulf R. Hedetoft (University of Copenhagen).

Data Availability

Due to the nature of the research, data sharing is not applicable to this article.

LLMs Disclosure

Grammarly was used solely for language editing (grammar, spelling, and style) and did not influence the scientific content, analysis, interpretation, or conclusions of the manuscript.

References

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (2024). Introduction—Senior home care for sale: Agency-brokered transnational live-in care in Europe. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 1–20). Sage.

Aulenbacher, B., Lutz, H., & Schwiter, K. (2021). *Gute Sorge ohne gute Arbeit? Live-in-Care in Deutschland, Österreich und der Schweiz* (1st ed.). Beltz Juventa.

Bartha, A., & Zentai, V. (2020). Long-term care and gender equality: Fuzzy-set ideal types of care regimes in Europe. *Social Inclusion*, *8*(4), 92–102. https://doi.org/10.17645/si.v8i4.2956

Belügyminisztérium. (2024). *Tartós Ápolás-Gondozásra Vonatkozó Stratégia 2030*.

Bonifacio, F., & Pais, I. (2025). *How platformisation is shaping the future of domestic work. A mapping of home care and cleaning platforms in six EU countries* (Working Paper 2025.08). European Trade Union Institute. https://www.etui.org/sites/default/files/2025-07/How%20platformisation%20is%20shaping%20the%20future%20of%20domestic%20work_2025.pdf

Börjesson, U., Bengtsson, S., & Cedersund, E. (2014). "You have to have a certain feeling for this work": Exploring tacit knowledge in elder care. *Sage Open*, *4*(2). https://doi.org/10.1177/2158244014534829

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Emberi Erőforrások Minisztériuma. (2020). *Tartós Ápolás-Gondozásra Vonatkozó Stratégia 2030*. https://cdn.kormany.hu/uploads/document/c/c6/c68/c68381aafe390e0744e99b10df3a98b3bd67ce67.pdf

Fiebig-Spindler, R. (2026). Selling care skills? The multiple meanings of training for polish live-in care workers in Germany. *Social Inclusion*, *14*, Article 11909. https://doi.org/10.17645/si.11909

Fodor, E. (2022). *The gender regime of anti-liberal Hungary*. Springer. https://doi.org/10.1007/978-3-030-85312-9

Gábriel, D., & Katona, N. (2024). Diversification of the senior home care market in Hungary: Informality and the operation of intermediaries. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 64–78). Sage.

Gazzaroli, D., D'Angelo, C., & Corvino, C. (2020). Home-care workers' representations of their role and competences: A diaphanous profession. *Frontiers in Psychology*, *11*, Article 581399. https://doi.org/10.3389/fpsyg.2020.581399

Giordano, C. (2021). The professionalisation of domiciliary care for the elderly: A comparison between public and private care service providers in Belgium. *International Journal of Sociology and Social Policy*, *41*(9/10), 1072–1088. https://doi.org/10.1108/IJSSP-06-2020-0226

Gottfried, H. (2022). Tacit knowledge in low-status eldercare work. *AMA Journal of Ethics*, *24*(9), E883–E889. https://doi.org/10.1001/amajethics.2022.883

Grenz, A., & von Kutzleben, M. (2024). Conceptualisations of good care and conflicts in live-in migrant care arrangements for people with dementia—Perspectives of family caregivers in Germany. *BMC Geriatrics*, *24*(1), Article 702. https://doi.org/10.1186/s12877-024-05283-9

Gyarmati, A. (2019). *Ageing and care for the elderly in Hungary. General survey and problems*. Friedrich-Ebert-Stiftung.

Gyarmati, A. (2022). *Situation of those working in elderly care in the EU and Hungary*. Friedrich-Ebert-Stiftung.

Gyarmati, A., Katona, N., Somorjai, I., Staller, J., & Szokoli, E. (2021). *Tartós Ápolás-Gondozás Stratégia 2021–2027*. Friedrich-Ebert-Stiftung Budapest.

Hayes, L., Johnson, E., & Tarrant, A. (2019). *Professionalisation at work in adult social care: Report to the All-Party Parliamentary Group on Adult Social Care*. GMB Union.

Hemmings, N., Oung, C., & Schlepper, L. (2022). *New horizons: What can England learn from the professionalisation of care workers in other countries?* Nuffield Trust. https://www.nuffieldtrust.org.uk/research/new-horizons-what-can-england-learn-from-the-professionalisation-of-care-workers-in-other-countries

Hussein, S., & Kispeter, E. (2025). *Policy drivers of social care workforce change: United Kingdom insights, impacts, and future directions*. Centre for Care. https://centreforcare.ac.uk/wp-content/uploads/2025/09/SH-EK-Policy-brief-May-2025-FINAL.pdf

Katona, N., & Gábriel, D. (2026). The quiet collapse: Authoritarian neoliberalism and the crisis of care of older people in Hungary. *Economy and Society*, *55*(2), 301–323. https://doi.org/10.1080/03085147.2026.2632445

Kontos, P. C., & Naglie, G. (2009). Tacit knowledge of caring and embodied selfhood. *Sociology of Health & Illness*, *31*(5), 688–704. https://doi.org/10.1111/j.1467-9566.2009.01158.x

Lutz, H. (2011). *The new maids: Transnational women and the care economy*. Palgrave Macmillan.

Meleg, S. (2025). Mi a gondoskodáspolitika? Megújítási vagy ideológia vezérelt kiszorítási kísérlet? *Párbeszéd: Szociális Munka Folyóirat*, *12*(1). https://doi.org/10.29376/parbeszed.2025.12/1/9

Needham, C., Allen, K., Burn, E., Hall, K., Mangan, C., Al-Janabi, H., Tahir, W., Carr, S., Glasby, J., Henwood, M., & McKay, S. (2023). How do you shape a market? Explaining local state practices in adult social care. *Journal of Social Policy*, *52*(3), 640–660. https://doi.org/10.1017/S0047279421000805

Ortiga, Y. Y., Wee, K., & Yeoh, B. S. A. (2021). Connecting care chains and care diamonds: The elderly care skills regime in Singapore. *Global Networks*, *21*(2), 434–454. https://doi.org/10.1111/glob.12281

Palenga-Möllenbeck, E. (2022). Making migrants' input invisible: Intersections of privilege and otherness from a multilevel perspective. *Social Inclusion*, *10*(1), 184–193. https://doi.org/10.17645/si.v10i1.4789

Palenga-Möllenbeck, E., Kyliushyk, I., & Fiebig-Spindler, R. (2026). The invisible hand of care: A typology of brokerage actors in migrant care labour. *Social Inclusion*, *14*, Article 11953. https://doi.org/10.17645/si.11953

Polanyi, M. (1966). *The tacit dimension*. Doubleday & Company.

Prieler, V. (2021). 'The good live-in care worker': Subject formation and ethnicisation in Austrian live-in care. *Sociológia – Slovak Sociological Review*, *53*(5), 483–501. https://doi.org/10.31577/sociologia.2021.53.5.18

Reinders, H. (2010). The importance of tacit knowledge in practices of care. *Journal of Intellectual Disability Research*, *54*(s1), 28–37. https://doi.org/10.1111/j.1365-2788.2009.01235.x

Szikra, D., & Öktem, K. G. (2023). An illiberal welfare state emerging? Welfare efforts and trajectories under democratic backsliding in Hungary and Turkey. *Journal of European Social Policy*, *33*(2), 201–215. https://doi.org/10.1177/09589287221141365

Vida, A. (2021). A professzionális gondoskodás konstrukciója és válsága az idősellátásban dolgozók perspektívájából. *Socio.Hu*, *11*(4), 69–84. https://doi.org/10.18030/socio.hu.2021.3.69

Wojczewski, S., Ernst, A., Bagheri, R., & Adler, V. (2023). *MigraCare—Weiterbildungsbedarf bei 24-Stunden-Betreuer*innen in Österreich*: *Ergebnisse einer Online-Umfrage**. Ludwig Boltzmann Gesellschaft – Open Innovation in Science Center. https://ois.lbg.ac.at/wp-content/uploads/sites/24/2024/03/MigraCare-Umfrage-Endbericht-0.2.pdf

About the Authors



Noémi Katona (PhD) is a sociologist and research fellow at the ELTE Centre for Social Sciences, Hungary, and an assistant professor at the Corvinus University of Budapest. Her main research interests are gender, migration, care work, and sexual labor.



Dóra Gábriel (PhD) is a sociologist and research fellow at the ELTE Centre for Economic and Regional Studies, Hungary, and at the ELTE Centre for Social Sciences, Hungary. Her main research interests are care marketization, the communitization of care, and international retirement migration.

Social Inclusion
2026 • Volume 14 • Article 12056
https://doi.org/10.17645/si.12056

cogitatio

ARTICLE

Open Access Journal

The Right to Care and Support: From Care Theory to Human Rights Law

Maroš Matiaško [1,2]

[1] Faculty of Humanities, Charles University in Prague, Czech Republic
[2] Faculty of Law, Palacký University in Olomouc, Czech Republic

Correspondence: Maroš Matiaško (maros.matiasko01@upol.cz)

Submitted: 30 January 2026 **Accepted:** 7 May 2026 **Published:** 15 July 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Care and support are central to social policy, yet they remain conceptually marginal within normative frameworks of human rights. This article examines the emergence of a right to care and support across feminist care theory, UN human rights standards, and Latin American constitutional jurisprudence. It argues that the emerging right to care, when reconstructed through the disability-rights language of support, should be understood not as a derivative social entitlement, but as an autonomous human right with a critical function in ensuring other human rights. Political theories of care expose the limits of autonomy-centred models of justice and social policy by foregrounding dependency, vulnerability, and relationality as constitutive features of human life. The article shows how these insights are translated, albeit unevenly, into international human rights discourse and crystallised through judicial reasoning that treats care as a condition of dignity and of the effectiveness of rights. Rather than proposing a programmatic catalogue of entitlements, the right to care and support is conceptualised as a relational and structural norm that reorients social policy towards the conditions of lived inclusion. The article concludes by arguing that recognising care as a matter of right challenges social policy to confront its underlying normative assumptions and to rethink the relationship between dependency, responsibility, and justice.

Keywords

dependency; human rights; Inter-American Court of Human Rights; political philosophy of care; right to care and support; United Nations

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Growing attention to care and support in legal and political discourse, including in relation to older people, has emerged alongside a widely shared diagnosis that existing arrangements of social reproduction are no longer sustainable or just, a condition increasingly described as a "care crisis." First articulated in the early 1990s by Susan S. Phillips (Phillips & Benner, 1994) and Arlie R. Hochschild (Hochschild, 1995), the concept has expanded into a broader critique of the organisation of social reproduction under late capitalism, encompassing demographic ageing, migration, gender inequality, and the erosion of public welfare infrastructures.

One response to this crisis has been an increasing turn to human rights language. As Luke Clements has argued, human rights discourse offers one of the most powerful contemporary vocabularies through which those directly involved in caring relationships can articulate their lived experience and contest their collective marginalisation (Clements, 2013). Rights language enables the translation of seemingly private relations of care and support into claims for public recognition, state responsibility, and social justice. Robin West has similarly argued that rights play their most protective role where aspects of human existence are systematically undervalued or insufficiently protected by ordinary political processes, with care being a paradigmatic example (West, 2002).

For the purposes of this article, care is understood not as a narrow interpersonal act of benevolence, nor merely as a set of welfare services, but as a socially organised practice through which human dependency, vulnerability, and interdependence are addressed. Following Fisher and Tronto (1990, p. 40), care may be understood as a "species activity" encompassing the practices through which human beings maintain, continue, and repair their world so that they can live in it as well as possible. Care is therefore both intimate and structural: It takes place in concrete relationships, but is shaped by labour markets, family norms, migration regimes, social-security systems, disability policy, and public infrastructures.

This understanding also resonates with the recent formulation of the Inter-American Court of Human Rights (henceforth, IACtHR or the Court), which describes care as a basic, inevitable, and universal need on which both human existence and the functioning of society depend. The Court further emphasises that care serves a fundamental individual and social function, enabling well-being, human activity, and the effective exercise of rights (IACtHR, 2025, paras. 47–49).

Over the last three decades, a distinct discourse on the right to care and support has gradually crystallised across several interconnected domains. First, within political philosophy, particularly feminist and care-ethical traditions, scholars have questioned the exclusion of care from dominant theories of justice, citizenship, and rights (Held, 2006; Kittay, 1999; Sevenhuijsen, 1998; Tronto, 1993). Second, within international human rights law, care has increasingly emerged as a cross-cutting concern, implicitly (Fredman, 2024) or as a self-standing right (Pautassi, 2007, 2023). Third, and most recently, judges, especially in Latin America, have begun to recognise care as an autonomous fundamental right, articulating its content and corresponding state obligations (e.g., Colombian Constitutional Court, 2023; Ecuadorian Constitutional Court, 2020; IACtHR, 2025).

The article deliberately uses the formulation "care and support." While feminist care theory has made visible the social and political value of care, and Latin American jurisprudence has primarily relied on the language of care, disability-rights standards require that this language be read alongside support, autonomy, independent living, and participation. Disability-rights scholarship and activism have also shown that the language of care may reproduce paternalistic assumptions when it frames persons primarily as passive recipients of protection. The concept of support is therefore used as a distinct but also corrective concept. It foregrounds autonomy, agency, participation, and independent living. Understood from this perspective, the right to care and support reorients the architecture of rights around relationality, interdependence, shared responsibility, and the prevention of violence and oppression. As the IACtHR has recently held, care is not derived from any single right. It constitutes an essential normative condition for the effectiveness of rights as such (IACtHR, 2025, paras. 108–113).

This article proceeds in several steps. Section 2 reconstructs the emergence of the right to care within political philosophy. Section 3 examines how care has been reframed within human rights discourse, culminating in the articulation of a complex, multidimensional right to care and support. Section 4 analyses the role of constitutional jurisprudence, particularly in Latin America, in giving this right concrete legal form. The concluding section reflects on the implications of the right to care for social inclusion, democratic governance, and the future of human rights.

2. Feminist Origins: From the Political Philosophy of Care to the Right to Care

The right to care and support emerges from an intellectual tradition rooted in the political philosophy of care, developed in critical dialogue with liberal theories of justice and rights. Early work, especially by Carol Gilligan, did not frame care in political or rights terms, but later feminist theorists challenged the separation between the private and public spheres and brought care into political theory. Seyla Benhabib helped open this move, while Joan Tronto placed care decisively at the centre of political analysis (Benhabib, 1986; Held, 2006; Tronto, 1993; Urban & Ward, 2020).

A key step was Fisher and Tronto's (1990) inclusive definition of care as a broad social practice rather than a private virtue. Later, in *Moral Boundaries*, Tronto (1993) further developed this insight by grounding care in need and identifying care as a response to human vulnerability and dependency. Human beings, Tronto argued, are not autonomous individuals who occasionally become dependent. Vulnerability and dependency are constitutive features of the human condition. A political order that fails to recognise this reality excludes vast domains of human experience from justice.

Other feminist theorists have followed Tronto's approach, albeit from different perspectives. Bubeck (1995) approached care through Marxist feminism, Sevenhuijsen (1998) linked it to democratic citizenship, and Kittay (1999) reformulated justice in light of dependency and the position of informal caregivers. Together, these interventions reconceptualised the political subject as embodied, relational, and vulnerable. Moreover, they also exposed a deeper limitation in liberal theories of rights and citizenship. The formally independent rights-bearing subject has historically depended on a background economy of care work, much of it unpaid and disproportionately performed by women, including racialised, migrant, and economically marginalised women (Fraser, 2016; Glenn, 2010; Kittay, 1999). Feminist political care theory reveals that this background is not external to justice but constitutive of it: autonomy, labour-market participation, political agency, and

the enjoyment of rights presuppose ongoing practices of social reproduction (Federici, 2012; Sevenhuijsen, 1998; Tronto, 1993; West, 2002). The right to care and support can therefore be understood as a response to this hidden infrastructure of rights. It asks not only whether women are formally equal before the law, but whether the social organisation of care and support allows all to enjoy rights without being consigned to unpaid sacrifice, economic precarity, or moralised expectations of availability (Fineman, 2004; Fredman, 2024; Kittay, 1999; Pautassi, 2007).

2.1. Theoretical Invention of the Right to Care: Caring as a Human Rights Concern

The near-absence of care in human rights theory is not accidental. Dominant liberal accounts of rights have often been shaped around subjects who approximate the ideal of independence. Those whose lives are structured by dependency, whether as caregivers or care recipients, appear as marginal or residual subjects of justice. The gradually developing political philosophy of care not only emphasised the necessity of linking care with questions of justice but also opened the way towards a different conception of rights (Engster, 2007).

This reconceptualisation aligns with relational theories of rights (Hansbury, 2022). According to these theories, rights structure relationships. For example, in relations of care and support, rights do not simply ensure equality or dignity; they constitute the experience of equality or dignity by shaping relations. Care becomes central within this framework because it is through caring relationships that individuals acquire, maintain, and exercise rights (Minow & Shanley, 1996; West, 2003; see also Nedelsky, 2011). Seen from this perspective, the move from care ethics to the right to care and support marks a transition from moral critique to normative expectations and possibilities for rights-based transformative change. In the political philosophy of care, the right to care has been discussed in the context of citizenship theory (Knijn & Kremer, 1997) or democratic theory (Tronto, 2013), with reference to needs and dependency (Engster, 2007; Noddings, 2002), Martha Nussbaum's capabilities theory (Busby, 2011; West, 2001, 2003), or the theory of the relational subject (Kittay, 2009).

One of the first works on the comprehensive right to care is an article by Trudie Knijn and Monique Kremer, who distinguished between the right to "time for care" and the right to "receive care" against the backdrop of the discussion on the obstacles to full citizenship faced by women. They propose that the concept of citizenship becomes inclusive by recognising care as a key dimension of citizenship (Knijn & Kremer, 1997).

The right to time for care must be analytically distinguished from the right to receive care; these are two interconnected but normatively different dimensions of the right to care. As Knijn and Kremer (1997) point out, the recipient of care cannot enforce their right to care from an informal caregiver, as such a relationship cannot be fairly structured through individual entitlement. The market cannot resolve this tension, as strict market logic would systematically exclude those who cannot afford to buy care. This implies an irreplaceable role for the state, whose responsibility is to organise and provide care as a public service available to all who need it.

It is the position of caregivers and their rights that became the central theme of Eva Kittay's work, *Love's Labor*. She did not yet explicitly speak of the "right to care," but formulated a normative framework that has fundamentally influenced human rights discourse. Kittay (2002, p. 242) proposes the concept of "doulia,"

which she defines as "the public responsibility to provide support for the caregiver so that the caregiver can give care without depleting herself and her resources." According to Kittay, this principle, which expresses the interdependence between the recipient of care and the caregiver, has not only a relational but also an institutional dimension, leading to a reconceptualisation of justice with regard to dependency (see also Kittay, 1999).

Robin West builds on Kittay in the context of human rights, explicitly introducing the "right of the doula," i.e., the right of caregivers to provide care without risking poverty or disadvantage (West, 2003, 2004). West argues that this right is comparable in its normative weight to classic liberal rights and that it is necessary to recognise it because care as work remains systematically unprotected by political and economic processes, its burden falls unequally on historically marginalised groups, especially women, and because care reflects the fundamental values associated with the physicality and vulnerability of human life. The "doula right" thus establishes enforceable claims to time, income, and services for caregivers, while being inextricably linked to the rights of care recipients and others; as West (2001, 2003) summarises, caregivers do not need rights that rest on a fiction of autonomy, but rights that openly recognise their relational reality and dependence on the support of others.

Within the political philosophy of care, rights are conceived in a distinctly pragmatic and instrumental manner (Held, 2006). From this perspective, the absence of recognition of a doulia right, that is, a right to care for the other and to sustain caring relationships, jeopardises not only care and support but also affects the whole family situation. This two-dimensional discourse of the right to care and support—caring and supporting the other and receiving care and support—was later taken up by Kittay (2009), who discussed a global right to care. Placing relationships at the centre of moral and legal analysis, Kittay argues that the most serious harm a person can suffer is the breakdown of their key relationships. To prevent such harm, she advances the idea of a universal right to care with two inseparable dimensions: the right to provide care and the right to receive it. For some, such as migrant women, the exercise of this right is marked by internal tension: While it is only imperfectly realised in their own lives, their labour simultaneously enables a more complete realisation of this right for those who employ them. The consequence is an interference with self-respect. While harm—a typical legal category—may remain analytically significant, the core concern in this relational perspective becomes the quality of relationships themselves. The guiding question shifts from identifying what harm has occurred to examining how a given legal situation, treatment, or practice shapes relationships: whether it renders them more considerate, secure, and resilient, or instead more threatening, oppressive, and fragile (Kittay, 2009).

Reorienting normative analysis towards the need for relationships can serve to justify the recognition of rights. Kittay's intervention explicitly foregrounds the situation of caregivers and the erosion of their key relationships with loved ones, arguing that recognising a complex right to care could render this neglected dimension visible within political and legal practice and, in turn, contribute to a more just social order. An emphasis on relationships and, thus, situatedness opens the possibility of understanding rights not merely as abstract entitlements but as instruments of concrete social transformation. Applied, for example, to the case of migrant care workers (Kittay, 2009), this perspective suggests that, beyond protection against precarious labour conditions, states should consider positive obligations to design and implement a range of supportive measures aimed at sustaining caregivers' own caring relationships with family members in their countries of origin, measures analogous to doulia rights that recognise the relational costs of care migration.

The right to care was subsequently explicitly addressed by Tronto in her 2013 book *Caring Democracy*, where she conceptualises care as a primary public value and a central concern of public practice, closely intertwined with democracy, citizenship, and equality. Tronto conceptualises care as a multi-phase process involving attentiveness to needs, responsibility for care, the practical work of caregiving, responsiveness to how care is received, and, finally, "caring with," which concerns the broader social and institutional conditions of trust, solidarity, and mutual respect.

This final dimension is especially important. Tronto argues that failures of "caring with" undermine trust in political and social institutions. Her response is to reconceive citizenship through universal vulnerability and to recognise a universal and complex right to care, one not confined to a single policy domain. This right includes three dimensions: the right to receive care, the right to care, including a negative freedom not to be coerced into care, and the right to participate in public decision-making about how care is organised and distributed (Tronto, 2013).

The political philosophy of care points toward a fundamental reorientation of law and social policy. Care and support are not peripheral concerns, but fundamental elements of social inclusion. Legal frameworks that ignore the central importance of care and support risk perpetuating exclusion even where formal rights and services exist. The shift toward the right to care and support reflects an attempt to address this gap. It signals a transition from treating care and support as a discretionary area of policy to recognising it as a matter of justice and rights, and thus of legal obligation and justiciability. In other words, moving care and support into the centre of how we imagine political societies affects how we design and enforce legal order (Herring, 2019). This development makes it necessary to engage in a political debate on how care and support should be organised, particularly in cases of "care poverty" (Kröger et al., 2019), where the right to care and support can be considered especially strong both epistemologically and politically (Rummery, 2025). It also determines the normative field in which such a debate must take place, including recognition of the critical tensions identified, particularly around the rights of persons with disabilities, typically concerning paternalism and independent living (Morris, 1997; Shakespeare, 2006; see also Maker, 2022).

3. The Road to Practice: Conceptualising the Right to Care and Support in Human Rights Law

The preceding section showed how feminist care theory transformed care from a moral relation into a question of justice, citizenship, and rights. Human rights law has followed a different but related path. The turn to human rights emerged as a strategic response to structural injustice. As Robin West argues, rights are most defensible where markets and majoritarian politics repeatedly fail to protect essential aspects of human life (West, 2001). Care and support exemplify such a domain: They are indispensable for human survival and flourishing, yet are consistently relegated to the private sphere, feminised, and rendered economically precarious.

Conceptually, the right to care and support is specific in three important respects. First, it is relational rather than individualistic. The right to care and support necessarily involves at least two positions: those who require care and those who provide it. These positions are not fixed; individuals move between them across the life course.

Second, the right to care and support is not exhausted by access to a specific service or benefit; rather, it concerns the conditions under which caring and supportive relations can be formed, sustained, and recognised without producing oppression. Time, continuity, trust, and attentiveness are not incidental but constitutive elements of care. A right to care and support that ignores these dimensions risks reproducing precisely the forms of domination and neglect it seeks to overcome.

Third, the right to care and support is structurally oriented. Rather than only addressing discrete instances of deprivation or abandonment, it targets the social organisation of care and support as such. This includes the distribution of care and support responsibilities across different actors, including the state. Indeed, the state's role in supporting or displacing care is indispensable. In this sense, it resonates with broader critiques of structural injustice, particularly feminist analyses of social reproduction.

3.1. Emergence of the Right to Care and Support: Caring and Supporting as a Human Rights Concern

Within international human rights law, care and support have long played an essential but largely implicit role. The human rights instruments address care primarily through the prism of status-based rights, most notably those of children, families, and, later, persons with disabilities. The 1959 Declaration of the Rights of the Child, for example, affirmed that a child should grow up in the care and responsibility of his parents, while simultaneously imposing duties on society and public authorities to provide special care to children deprived of adequate family support. This formulation already combined private and public responsibility, anticipating later debates on shared care obligations.

Similarly, care-related duties appear across core human rights treaties without being explicitly named. The International Covenant on Economic, Social and Cultural Rights protects rights to health, social security, and an adequate standard of living, all of which presuppose access to care and support. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) goes further by explicitly recognising the social value of maternity and addressing the unequal distribution of unpaid care work as a source of gender inequality. According to Article 11.2 (c) of the CEDAW, states should provide the necessary social support services to enable parents to combine family responsibilities with work and participation in public life, in particular by establishing community services for the care and support of children (A/80/170, para. 21). The role of the state is also emphasised by the requirement that states study domestic care, collect data on its extent, and include it in the calculation of gross domestic product (CEDAW/RG/17, 1991). Yet even here, care remains fragmented across different rights and policy domains.

In the context of women's rights, increasing emphasis is placed on the sharing of responsibility for care and support, often articulated through the principle of co-responsibility (CEDAW/RG/21, 1994). This principle refers, inter alia, to the active involvement of men in care and support tasks and to the obligation of the state to design legal norms and care-related policies in a gender-neutral manner, without excluding men from the possibility of providing care (A/52/38). Beyond formal neutrality, the principle also requires states to adopt concrete and targeted measures that enable men's active participation in care, thereby mitigating the structurally unequal impacts of care responsibilities on women. At the same time, co-responsibility entails recognition of the state's irreplaceable role and its comprehensive responsibility for care and support, including care for caregivers themselves.

The CEDAW Committee addressed the rights of women as informal caregivers in the decision *Natalia Ciobanu v. Moldova* (CEDAW/C/74/D/104/2016). The case concerned a sixty-year-old applicant who was denied an adequate old-age pension because she spent twenty years caring for her daughter with a severe disability. The period spent caring was not counted as a contributory insurance period under national law. The applicant argued that the pension framework disproportionately disadvantaged women, who are traditionally the primary providers of care. As a result, women were rendered economically dependent on their husbands not only during periods of intensive care, but also afterwards, since care work did not generate pension entitlements. Moreover, the system exposed them to heightened existential insecurity, compounded by the frequent experience of abandonment by partners once they "learn how it is to live with and take care of a severely disabled child" (*Ciobanu v. Moldova*, 2019, para. 3.1).

Unsurprisingly, the CEDAW Committee found a violation of the applicant's rights, reaffirming that even where caregivers do not contribute to social security due to unpaid domestic care, the state has a positive obligation to ensure access, in old age, to non-contributory benefits, social services, and other forms of assistance. Such non-contributory schemes must also take account of the structural reality that women are more frequently exposed to poverty, more often bear sole responsibility for care, and are less likely than men to qualify for contributory pensions. According to the CEDAW Committee, women caregivers should not be forced to sacrifice their life projects because of care responsibilities, but should have a right to support that enables, rather than compels, the meaningful integration of care and support into their professional and social lives.

The UN Convention on the Rights of Persons with Disabilities (CRPD) does not recognise a right to care and support as such. It does, however, place support at the centre of the right to live independently and be included in the community, especially through Article 19. Moreover, it contains provisions of a manifestly relational nature that foreground the position of caregivers and the state's role in protecting their rights, notably in the context of family life, where the Preamble affirms that the family as a whole is entitled to protection by society and the state.

The conceptual emphasis on support rather than care within disability-rights discourse, as noted by the UN Special Rapporteur on the Rights of Persons with Disabilities, mirrors the understanding of care as an ambivalent concept due to its oppressive connotations (Aguilar, 2016, paras. 23–24). Simply put, people with disabilities associate care with experiences of oppression (Williams, 2001). On a theoretical level, according to Tronto, the answer to this risk is to combine care with a theory of justice and to ensure that care is "relentlessly democratic in its organization" (Tronto, 2013, p. 171). At its core, it is about fulfilling a certain idea of what a political society should look like. According to Tronto, it should be a caring democracy.

The question is how to express this idea in legal terminology without reproducing the very hierarchies that disability-rights scholars and activists have criticised (Maker, 2022; Morris, 1997; Shakespeare, 2006). The answer is not to discontinue the use of the term "care," despite criticism. Rather, it is to create a conceptual constellation of care and support that would balance the risks of paternalism and parochialism. The difference does not lie in the claim that care is inherently paternalistic and support is inherently emancipatory. Both concepts require institutional design. Care must be democratised so that it does not descend into blind protectionism, while support must remain relationship-based so that it does not become merely a market-based service.

The concept of support should be understood in relation to the experience of independence—thanks to support, people can experience independence even in very dependent situations—in both the personal and public spheres (Shakespeare, 2000). Support is directed not merely at protection or maintenance, but at enabling persons to pursue self-actualisation in the world (Quinn, 2022, para. 21), which necessarily includes participation (Morris, 2001). The dyadic constellation of care and support has also been recognised by the IACtHR (2025, para. 202), according to which:

> In summary, the Court finds that States have the obligation to adopt the measures required to ensure the right to care of persons with disabilities from a perspective of "support" and not merely of "attention," within the framework of respect for their rights to autonomy, independence, safety, and a life free from violence. This means that the care and support provided to persons with disabilities should be based on their recognition as subjects of rights and not merely as recipients of care.

As regards the relational logic, it implies that failures in the availability of services affect not only persons with disabilities but also their close relatives, their right to care and to self-care, and conversely obliges the state to provide adequate, accessible support services, including counselling, respite, and financial support, as an integral part of ensuring an adequate standard of living and social protection under Article 28 of the CRPD, not only for persons with disabilities but also for their families (CRPD/C/GC/5, para. 68).

The CRPD Committee examined these issues in *Bellini v. Italy*, a case concerning an informal caregiver providing round-the-clock care to both her daughter with severe disability and her ill partner. The CRPD Committee emphasised a relational understanding of rights, noting that the lack of legal recognition and support for family caregivers has serious consequences not only for caregivers themselves but also for the rights of persons with disabilities, including their ability to live independently in the community. It further stressed that caregivers must be able to make autonomous life decisions and claim support tailored to their specific needs, just as persons with disabilities do.

Although the state pointed to existing measures, such as limited paid leave or extended care leave, the CRPD Committee found these insufficient because they did not address situations requiring continuous assistance. What was missing were individualised and comprehensive forms of support, including financial assistance, affordable and accessible services, respite and home care, counselling, flexible working arrangements, housing support, and recognition of caring periods within social security systems. The CRPD Committee underlined that providing generic services is not enough: Support must be designed around the actual circumstances and needs of families. The CRPD Committee therefore found a violation of her rights, emphasising the risks that arise when adequate support is absent. These include financial and social precarity for families and the resulting pressure toward unwanted institutionalisation, with severe consequences for family life and care relationships. While the decision stops short of explicitly recognising a right to care and support, it significantly contributes to defining its substance, illustrating how UN treaty body jurisprudence, together with cases such as *Ciobanu v. Moldova*, marks a gradual shift toward a more explicit articulation of state obligations in the field of care and support.

A specific lesson stemming from *Bellini v. Italy* and *Ciobanu v. Moldova* concerns the problem of enforcing the right to care at the expense of its moral and relational character. A legal order cannot force one person to care about another, and any attempt to compel intimate care and support from a specific person would

risk violating the rights, autonomy, and bodily integrity of the caregiver. This objection is decisive against a privatised or interpersonal reading of the right to care and support. It is not, however, decisive against a structural human-rights reading. The right to care and support should be understood as a claim against the state and relevant institutions to organise conditions under which care can be provided, received, refused, shared, and supported without coercion. Its legal content, therefore, lies not in compelling affection or sacrifice, but in duties to provide available and accessible services and frameworks, including personal assistance, respite, income protection, social-security recognition of care periods, community-based support, labour protections, and participatory mechanisms through which caregivers and care and support recipients can enjoy all their human rights on an equal basis with others.

4. Judicial Construction of the Right to Care

Existing case law has so far articulated care more explicitly than support. This article analyses the case law alongside standards concerning the rights of persons with disabilities in the areas of support, autonomy, independent living, and participation, with a view to clarifying the broader concept of the right to care and support. The emergence of this right within human rights discourse does not represent a straightforward extension of existing rights, such as the rights to social security or to health. Rather, it reflects a deeper conceptual shift: Some courts have begun to articulate care not merely as an object of policy or a derivative characteristic of already recognised rights, but as a self-standing human right, and, more importantly, as a condition affecting the enjoyment and exercise of other rights.

Decisive in this regard has been the Latin American trajectory, where feminist legal scholarship, regional policy processes, and social-movement activism jointly shaped the emergence of care and support as a rights-based agenda. It was within this region that the right to care as a three-dimensional right was introduced and promoted (Pautassi, 2007), resulting in a unique judicial evolution (Pautassi, 2025). The decisive moment within the judicial trajectory is the advisory opinion of the IACtHR, which was preceded by important judgments of the Ecuadorian (2020) and Colombian (2023) Constitutional Courts. From a theoretical perspective, alongside Tronto, courts have drawn on the work of the Argentine feminist legal theorist Laura Pautassi, who, as early as 2007, raised the question of how to integrate the complexity of care into the logic of subjective rights. Pautassi criticised the dominant approach that treats care either as a service targeted at "needy" groups or as a private responsibility of the family and proposed a reorientation toward a universal entitlement (Pautassi, 2007, 2023). This academic development was accompanied by feminist activism and regional policy processes, including advocacy networks that connected civil society, academia, and state institutions to advance care as a public agenda (Navarro, 2025).

4.1. Three Examples of Judicial Recognition

It appears that judicial recognition of the right to care has not followed a single path of argument. Instead, courts have reached this conclusion through different trajectories. The Ecuadorian Constitutional Court, the Constitutional Court of Colombia, and the IACtHR each approach the right to care from distinct perspectives. The Ecuadorian and Colombian cases are constitutional decisions within national constitutional frameworks, whereas the UN materials and the Inter-American Advisory Opinion fall under international human rights law. The legal force is not identical, but together, they show how care moves from political theory into positive legal reasoning.

The decision of the Ecuadorian Constitutional Court (2020) concerned violations of the rights of women who were pregnant, breastfeeding, or on maternity leave while employed in the public sector. Drawing on the lived experiences of nineteen women, the court identified systemic barriers such as workplace pressure during pregnancy, discriminatory job reassignment or dismissal after maternity leave, lack of facilities for breastfeeding, and pervasive stigmatisation. These experiences were not treated as isolated incidents but as manifestations of universal obstacles faced by women in care-related roles.

A central move in the reasoning of the Ecuadorian Constitutional Court was the distinction between production and social reproduction. While productive activities are socially recognised and economically rewarded, care-related activities that sustain daily life and social bonds remain structurally invisible. According to the court:

> 89. Society requires two types of activities that are fundamental to its existence and maintenance: production and reproduction.
>
> 90. Reproductive activities are equally important and essential for life in society, and are those related to care and the daily construction of social and emotional bonds. Activities such as feeding, cooking, changing nappies, cleaning the house, washing and ironing clothes, playing, and caring for the sick are not valued socially or economically.
>
> 91. Production and reproduction activities are complementary, and both are equally important and essential for a life of fulfilment…and dignity.

The court emphasised that production and reproduction are not hierarchical but complementary: Both are indispensable for a dignified life. This insight enabled the court to legitimise legal intervention in what is often framed as the private sphere of care and to translate the systematic devaluation of care into the language of structural discrimination.

Building on this foundation, the court conceptualised care, drawing explicitly on Tronto, as a practice essential to sustaining life and social cohesion (Ecuadorian Constitutional Court, 2020, para. 92). The persistent overvaluation of production and undervaluation of reproduction were identified as a form of inequality requiring a concrete legal response: the recognition and development of the right to care, so that care would be fairly valued and justly distributed. Crucially, the court rejected any reduction of this right to a "women's right" or to the rights of specific groups, such as older persons, affirming its universal character instead.

The court further grounded this argument in the idea that while care needs are common to all humans, their intensity varies across the life course. From the combination of universal dependency and situational vulnerability, the Ecuadorian court derived a three-dimensional structure of the right to care: the right to provide care, the right to receive care, and the right to self-care. This framework explicitly reflects core insights of the political philosophy of care concerning interdependence and fluctuating vulnerability.

The Colombian Constitutional Court (2023), by contrast, anchored its recognition of the right to care in the notion of a structural "care crisis." Responding to a case involving the lack of community-based services for a young child with Down syndrome, the court held that the issue could not be reduced to the right to health.

Instead, it exposed a broader social problem in which increasing care needs, women's labour market participation, and demographic change collide with inadequate public support, generating gendered and economic injustices. In concrete terms, the court reasoned:

> 95. The case analysed here…highlights how the most vulnerable individuals, such as children with disabilities, are severely affected in their access to fundamental rights such as health care when they do not have caregivers. It also shows how the simple statement of the mandate of solidarity, to assign the care component to families, is insufficient without addressing the gender perspective, insofar as women are the ones who take on most of these tasks, and when circumstances such as being in the formal labour market arise, children are paradoxically faced with the dilemma of accessing health services only if their mother gives up the job that provides them with the minimum subsistence income. That is why addressing these types of issues goes beyond the traditional scope of health and requires, as argued here, a perspective that views care as a right.

Recognising care as an autonomous right allowed the court to address these intersecting dimensions through principles of equality, non-discrimination, and shared responsibility.

A third and distinct approach emerges from the 2025 advisory opinion of the IACtHR (2025), which framed care as an essential normative condition for the effective enjoyment of human rights. The court rejected the idea that care derives from a single substantive right, such as health or social security. Instead, it conceptualised care as a condition that critically forms the enjoyment and exercise of rights, thereby elevating it to a transversal human rights principle with unique value, even though it can be found as a component of many already recognised and well-defined rights. The formulation of this position is doctrinally significant because it locates care as a precondition for the enjoyment of rights—thus as a crucial normative element of broader rights architecture—rather than as their consequence:

> 108.…In the first place, care is an indispensable means for the enjoyment of the right to a dignified life…insofar as it allows individuals to develop fully and maintain their life project, particularly in situations of physical, mental or social vulnerability. Furthermore, care is fundamental to the protection of the right to personal integrity…since its omission may lead to situations of abandonment or neglect that compromise the dignity and physical or psychological integrity of persons, according to their stage of life and their differentiated capacities. These elements show that access to care is not merely a welfare measure, but rather an essential normative condition for the effectiveness of human rights.

By normatively framing care—and, logically, support as well, even though the IACtHR has been regrettably overly silent on support—the court shifts the analytical focus from individual entitlements to institutional arrangements. The question is no longer merely whether a specific service has been provided, but whether the overall organisation of care prevents situations of abandonment, neglect, or degrading treatment and discrimination for both caregivers and care recipients. In the court's words, it can be recognised that care is an essential component of several rights, yet:

> [Its] fragmented treatment—limited to partial aspects within other rights—is insufficient. This partial approach does not adequately address the numerous ways in which the omission of care can affect

> the dignity of individuals, nor does it provide adequate guarantees to those who perform care work. (IACtHR, 2025, para. 112)

Without recognising the right to care and support, the effective guarantee of human rights remains incomplete. What is at stake is the overall human rights architecture and its efficiency. Taken together, these strands of jurisprudence present the right to care as a context-sensitive right that can be juxtaposed to the limitations of traditional, individualistic human rights doctrine. It is grounded in relationality, interdependence, and solidarity, but it also has a strong instrumental value, opening possibilities for transformative change within the human rights paradigm.

5. Conclusion

By tracing the right to care and support across political philosophy, human rights discourse, and constitutional jurisprudence, the article shows how care and support have begun to move from the margins of human rights reasoning towards its conceptual centre. This shift is especially visible in Advisory Opinion OC-31/25 (IACtHR, 2025), where the IACtHR characterises care as an essential normative condition for the effective enjoyment of human rights. Political philosophy of care exposed the limitations of autonomy-centred models of justice and reoriented theoretical attention towards vulnerability, dependency, and relationality. Human rights law, following this theoretical development, has translated these insights, sometimes even explicitly, into the language of legal claims and obligations.

The gradual invention of the right to care and support has important implications for social inclusion. The recognition of the right to care—and support—has the potential to open up practical opportunities not only to address individual instances of exclusion but also oppressive and precarious structural arrangements. Moreover, its relational structure integrates the positions of caregivers and care recipients, enabling a more complex and nuanced structural perspective. Violations would rarely appear as isolated acts. There would be a pattern of neglect, underfunding, and regulatory failure. The right to care allows the judiciary to focus on the institutional design of care systems. It equips courts and policymakers with a normative lens to identify forms of harm that remain invisible in other rights analyses.

Looking ahead, the emergence of the right to care and support opens several avenues for further research and practice. Comparative constitutional analysis can deepen understanding of how care is articulated across different legal cultures. Empirical research can examine how care- and support-based rights claims are mobilised by caregivers and care recipients. Policy analysis can examine how care and support systems can be redesigned in line with principles of co-responsibility, with a gendered perspective on care and support. In an era marked by demographic change, social fragmentation, and repeated crises, the question is no longer whether societies can afford to recognise care as a matter of rights, but whether they can afford not to. By making care and support visible as a foundational condition of human rights protection and thus an inherent building block of rights architecture, the right to care and support offers a powerful normative response to contemporary forms of exclusion, and a reorientation of rights towards the realities of diverse situations of vulnerability.

Acknowledgments

The author would like to thank the anonymous reviewers and editors for their constructive and insightful comments. The author is also thankful to Petra Ezzeddine for her comments and suggestions.

Funding

This work was supported by the project CareOrg—Researching the Transnational Organization of Senior Care, Labor and Mobility in Central and Eastern Europe (2023–2027; https://careorg.eu), funded by the Volkswagen Foundation (VolkswagenStiftung).

Conflict of Interests

The author declares no conflict of interests.

LLMs Disclosure

ChatGPT-4o and Grammarly were used for language checking and editorial refinement. The author reviewed and approved all final content, all analytical interpretations, and argumentation. Final editorial decisions are the author's own.

References

Aguilar, C. D. (2016). *Report of the special rapporteur on the rights of persons with disabilities* (A/HRC/34/58). UN Office of the High Commissioner for Human Rights. https://www.ohchr.org/en/documents/reports/report-special-rapporteur-rights-persons-disabilities

Benhabib, S. (1986). The generalized and the concrete other: The Kohlberg–Gilligan controversy and feminist theory in feminism as critique. *Praxis International*, *5*(4), 402–424.

Bubeck, D. E. (1995). *Care, gender, and justice*. Oxford University Press.

Busby, N. (2011). *A right to care? Unpaid care work in European employment law*. Oxford University Press.

Ciobanu v. Moldova, CEDAW/C/74/D/104/2016 (2019).

Clements, L. (2013). Does your carer take sugar? Carers and human rights: The parallel struggles of disabled people and carers for equal treatment. *Washington and Lee Journal of Civil Rights and Social Justice*, *19*, 397–444. https://scholarlycommons.law.wlu.edu/crsj/vol19/iss2/8

Colombian Constitutional Court. (2023). *Judgment No. T-583/23*.

Ecuadorian Constitutional Court. (2020). *Judgment No. 3–19-JP/20*.

Engster, D. (2007). *The heart of justice: Care ethics and political theory*. Oxford University Press.

Federici, S. (2012). *Revolution at point zero: Housework, reproduction, and feminist struggle*. PM Press.

Fineman, M. A. (2004). *The autonomy myth: A theory of dependency*. The New Press.

Fisher, B., & Tronto, J. C. (1990). Toward a feminist theory of caring. In E. K. Abel & M. Nelson (Eds.), *Circles of care: Work and identity in women's lives* (pp. 35–62). State University of New York Press.

Fraser, N. (2016). Contradictions of capital and care. *New Left Review*, *100*, 99–117. https://doi.org/10.64590/nt2

Fredman, S. (2024). Care as a constitutional value. *International Journal of Constitutional Law*, *22*(3), 741–771. https://doi.org/10.1093/icon/moae047

Glenn, E. N. (2010). *Forced to care: Coercion and caregiving in America*. Harvard University Press. https://doi.org/10.2307/j.ctv1p6hnw0

Hansbury, T. (2022). *The relational self and human rights: Paul Ricoeur's hermeneutics of suspicion* (1st ed.). Birkbeck Law Press.

Held, V. (2006). *The ethics of care: Personal, political, and global*. Oxford University Press.

Herring, J. (2019). *Law and the relational self*. Cambridge University Press.

Hochschild, A. R. (1995). The politics of culture: Traditional, cold modern, postmodern, and warm modern ideals of care. *Social Politics: International Studies in Gender, State, and Society*, *2*(3), 331–346. https://doi.org/10.1093/sp/2.3.331

Inter-American Court of Human Rights. (2025). *Advisory opinion OC-31/25*.

Kittay, E. F. (1999). *Love's labor: Essays on women, equality, and dependency*. Routledge. https://doi.org/10.4324/9781315021218

Kittay, E. F. (2002). Love's labor revisited. *Hypatia*, *17*(3), 237–250. https://doi.org/10.1111/j.1527-2001.2002.tb00951.x

Kittay, E. F. (2009). The moral harm of migrant carework: Realizing a global right to care. *Philosophical Topics*, *37*(2), 53–73. https://doi.org/10.5840/philtopics20093724

Knijn, T., & Kremer, M. (1997). Gender and the caring dimension of welfare states: Toward inclusive citizenship. *Social Politics: International Studies in Gender, State & Society*, *4*(3), 328–361. https://doi.org/10.1093/oxfordjournals.sp.a034270

Kröger, T., Puthenparambil, J. M., & Aerschot, L. V. (2019). Care poverty: Unmet care needs in a Nordic welfare state. *International Journal of Care and Caring*, *3*(4), 485–500. https://doi.org/10.1332/239788219X15641291564296

Maker, Y. (2022). *Care and support rights after neoliberalism: Balancing competing claims through policy and law*. Cambridge University Press. https://doi.org/10.1017/9781108750479

Minow, M., & Shanley, M. L. (1996). Relational rights and responsibilities: Revisioning the family in liberal political theory and law. *Hypatia*, *11*(1), 4–29. https://doi.org/10.1111/j.1527-2001.1996.tb00504.x

Morris, J. (1997). Care or empowerment? A disability rights perspective. *Social Policy & Administration*, *31*(1), 54–60. https://doi.org/10.1111/1467-9515.00037

Morris, J. (2001). Impairment and disability: Constructing an ethics of care that promotes human rights. *Hypatia*, *16*(4), 1–16. https://doi.org/10.1111/j.1527-2001.2001.tb00750.x

Navarro, F. M. (2025). Between activism and academy: Lobby and advocacy about care in Latin America. *Social Politics: International Studies in Gender, State & Society*, *32*(2), 310–332. https://doi.org/10.1093/sp/jxaf025

Nedelsky, J. (2011). *Law's relations: A relational theory of self, autonomy, and law*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195147964.001.0001

Noddings, N. (2002). *Starting at home: Caring and social policy*. University of California Press.

Pautassi, L. (2007). *El cuidado como cuestión social desde el enfoque de derechos*. CEPAL.

Pautassi, L. (2023). *The right to care: From recognition to its effective exercise*. Friedrich-Ebert-Stiftung.

Pautassi, L. (2025). Bases normativas y fundamentos políticos del derecho humano al cuidado. In M. Color Vargas & M. I. Páez Villa (Eds.), *El derecho humano a los cuidados: Una agenda en construcción* (pp. 87–138). Suprema Corte; Unidad General de Conocimiento Científico y Derechos Humanos.

Phillips, S. S., & Benner, P. (Eds.). (1994). *The crisis of care: Affirming and restoring caring practices in the helping professions*. Georgetown University Press.

Quinn, G. (2022). *Report of the special rapporteur on the rights of persons with disabilities* (A/HRC/52/32). UN Office of the High Commissioner for Human Rights. https://www.ohchr.org/en/documents/thematic-reports/ahrc5232-transformation-services-persons-disabilities

Rummery, K. (2025). Care poverty and conflicts in social citizenship: The right to care? In T. Kröger, N. Brimblecombe, R. Rodrigues, & K. Rummery (Eds.), *Care poverty and unmet needs: Inequalities in theory and practice* (pp. 15–28). Policy Press.

Sevenhuijsen, S. (1998). *Citizenship and the ethics of care: Feminist considerations of justice, morality and politics*. Routledge. https://doi.org/10.4324/9780203169384

Shakespeare, T. (2000). *Help*. Venture Press.

Shakespeare, T. (2006). *Disability rights and wrongs*. Routledge. https://doi.org/10.4324/9780203640098

Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.

Tronto, J. C. (2013). *Caring democracy: Markets, equality, and justice*. New York University Press.

Urban, P., & Ward, L. (Eds.). (2020). *Care ethics, democratic citizenship and the state*. Palgrave Macmillan.

West, R. (2001). Rights, capabilities, and the good society. *Fordham Law Review*, *69*, 1901–1932. https://ir.lawnet.fordham.edu/flr/vol69/iss5/14

West, R. (2002). The right to care. In E. F. Kittay & E. K. Feder (Eds.), *The subject of care: Feminist perspectives on dependency* (pp. 88–107). Rowman & Littlefield.

West, R. (2003). *Re-imagining justice*. Ashgate.

West, R. (2004, April 1). A right to care. *Boston Review*. https://www.bostonreview.net/forum/anne-l-alstott-what-we-owe-parents/robin-west-right-care

Williams, F. (2001). In and beyond new labour: Towards a new political ethics of care. *Critical Social Policy*, *21*(4), 467–493. https://doi.org/10.1177/026101830102100405

About the Author



Maroš Matiaško (PhD) is a post-doc researcher at the Department of Social and Cultural Anthropology, Faculty of Humanities, Charles University in Prague, and an assistant professor at the Department of Constitutional Law, Faculty of Law, Palacký University in Olomouc, and the Department of Social Work, Faculty of Arts, Charles University in Prague. His research focuses on the intersection of theory and practice of human rights, care, solidarity, and vulnerability.

Social Inclusion
2026 • Volume 14 • Article 12060
https://doi.org/10.17645/si.12060

cogitatio

ARTICLE

Open Access Journal

Senior Care in Wartime Ukraine: A Fragmented Continuum of Arrangements Inside an "Unpromising Sector"

Oksana Dutchak [1], Olena Fedyuk [2], and Anna Oksiutovych [1]

[1] CareOrg Project, Ukraine
[2] CareOrg Project, Germany

Correspondence: Oksana Dutchak (ok.dutchak@gmail.com)

Submitted: 30 January 2026 **Accepted:** 28 April 2026 **Published:** 3 June 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Care for older people in Ukraine is an "unpromising domain" of social policy, situated at the bottom of care hierarchies and systematically marginalized through chronic underfunding, weak institutional development, and political invisibility. The provision of care for older adults has been shaped by long-term demographic aging, neoliberal reforms, and a strongly familialistic care regime, and it relies predominantly on families operating within a fragmented and poorly regulated landscape. Russia's full-scale invasion in 2022 has resulted in another devastating blow to structural conditions, not only further destabilizing care infrastructures but also disrupting informal networks of support, rupturing family ties, and deepening inequalities in access to care. In this article, we situate current arrangements within a longer historical trajectory from the Soviet period through to the post-independence reforms. Relying on statistical data, policy analysis, and 40 in-depth interviews, we trace how the deprioritization of care for older persons—that is, its decentralization, marketization, and a shift to residual public provision—has produced a fragmented continuum of care rather than a coherent care regime. The war is acting as an amplifier rather than representing a rupture; it is magnifying existing deficits and increasing reliance on unstable ad hoc solutions. These dynamics are profoundly gendered, with middle-aged and older women bearing disproportionate responsibility for both unpaid and low-paid care labor. We argue that the persistent framing of care for older people as an unpromising policy domain risks reproducing its marginalization in the postwar reconstruction.

Keywords

care for older people; familialism; gendered care labor; neoliberalism; social policy; Ukraine; war

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Like most EU countries, Ukraine has been dealing with the challenges of population aging for decades. A combination of socioeconomic problems, declining birth rates, and the outmigration of the working-age population has been collectively described as "aging from below" (Semigina & Karkach, 2021). Unlike other countries in the region, however, Ukraine has experienced significant military, socioeconomic, and political turmoil from 2014 onward. The war that broke out in Eastern Ukraine accelerated these demographic changes, while Russia's full-scale invasion in 2022 rendered them dramatic.

Marxist feminist theories of social reproduction argue that care for older people is structurally located at the bottom of care hierarchies (Dutchak, in press), though how that plays out depends on complex local contexts. Over the years of post-Soviet transformation in Ukraine, it came to be seen as an unpromising domain shaped by extreme demographic pressures, chronic underfunding, public and political invisibility, and, in recent years, the war waged on the Ukrainian state and society. This neglect, we argue, resulted in care for older people being pushed to the very bottom of care hierarchies in Ukraine, exacerbating pressure on families and especially on women with multiple other vulnerabilities. Here, the gendered cultural norms naturalize care as women's responsibility to further justify the lack of and political apathy towards finding alternative and sustainable options.

In this article, we explore familialized, fragmented, and publicly and politically invisibilized care arrangements for older people. We also consider experiences of care in the context of neoliberal austerity and war. Existing research shows that families consistently and invariably remain the main providers of care for older people in Ukraine (Strelnyk, 2026), despite changes in the political elites, economic models, and demographic conditions. We therefore ask: How do families navigate the existing care infrastructure and arrange care under various circumstances shaped by broader state policies and the ongoing war? To address this question, we first map the historical context of care for older people in Ukraine. We begin by summarizing the current state of care provision for older people and outlining the existing landscape of care infrastructure. We then provide an overview of key transformations in this infrastructure over the decades of post-Soviet transition, cementing the unpromising position of the care sector and policy domain. We also cover the post-2014 period of neoliberal austerity, reforms, and war, which tightened care hierarchies, resulting in increasing neglect and fragmentation (Dutchak, in press) at the bottom of the care sector. This overview allows us to better understand families' options of support regarding care for older people as their care needs evolve over time: for example, the availability and accessibility of options beyond family networks, the fragmenting influence of (or rather lack of) state policies, broader structural processes, and, eventually, war.

We demonstrate how families patch together care from a variety of sources, including arrangements based on kinship and reciprocity as well as those located in the gray areas of social provisioning and the for-profit care sector. While we focus on care arrangements within families, we also examine the solutions families seek out and turn to. This enables us to reflect on the scope of the care available for older people, and on how it is mobilized and shaped by the broader context of a familialistic model of care.

Our article is based on an analysis of statistical data, secondary sources, and 40 in-depth interviews with families (20), care workers (10), care providers and NGOs (10), and experts (2) in the field of care for older people. Numerous obstacles to accessing data in wartime exist: These include delays, restrictions, and gaps in

the publication of statistics, while some data (for instance, from occupied territories) is currently inaccessible. Moreover, during the field research, we discovered that the marginalization of senior care problems in public and political narratives and the trivialization of in-family care make some people reluctant to speak about their experiences: this was especially true for care workers but also for in-family carers. To overcome these obstacles, we drew on extended personal and social networks, using self-selection and snowball approaches to conduct interviews. We rely on a "patchwork ethnography" approach as an inevitable and yet productive way to research in "less-than ideal…conditions" (Günel & Watanabe, 2024). Despite these limitations, the combined methodology allows us to examine care for older persons in Ukraine from multiple perspectives and to situate experiences of care use and care provision within a broader sociopolitical and historical context.

2. Senior Care at the Bottom of the Care Hierarchy

Across the globe, care for older persons remains a relatively neglected care sector. Marxist feminist theories of social reproduction allow us to comprehend both the overall hierarchical structures of capitalist socioeconomic reality and labor (Bennholdt-Thomsen & Mies, 2000, p. 31) and the different values attached to bodies as bearers of labor power (Vogel, 2000). These embedded inequalities create care hierarchies within which resources are distributed unequally, leading to the uneven development of care infrastructure and the fragmentation of care labor, even more prominently under conditions of austerity and crisis (Dutchak, in press). Despite population aging, Ukraine has seen no socialization or outsourcing of care for older people on any significant scale, leaving the familialistic model of care dominant and care arrangements individualized and fragmented. As we will show, these deficiencies stem from decades of neoliberal policies tightening care hierarchies, promoting the privatization of care and halting substantial social reforms. The war has further exacerbated the situation.

2.1. Care for Older People in Ukraine Before 2022

While a detailed historical analysis of care arrangements in Ukraine lies beyond the scope of this article, it is worth outlining that the Soviet model of care for older people is the one that had the most bearing on the institutions and organization of such care in Ukraine. Indeed, the Ukrainian government launched its first comprehensive reform of social services only in 2020. The Soviet model has been described as familialistic and informal (Bezrukov, 2003; Semigina & Karkach, 2021), barely supported by a rudimentary, selective, closed state system, with almost no other actors providing care for older persons outside families (Semigina & Karkach, 2022). When Ukraine became independent, it had an underdeveloped system of residential care for older people and a gradually expanding system of visiting care organized through community centers (Bezrukov & Verzhikovskaya, 1994; Palley & Romanenkova, 2004), as part of the model established in the late Soviet period. During the 1990s, the existing system of long-term care was understood as fragmented, underfinanced, unevenly developed, and insufficient to address the growing demand for care provision driven by demographic change (Bezrukov, 2003). This decade was also marked by the steady development of a private nonprofit infrastructure of care for older persons, including charities and ethnic and religious organizations, as well as international actors such as the Red Cross (Bezrukov, 2003; Palley & Romanenkova, 2004). While for-profit actors likely emerged at that time, this sector grew rapidly in the first decade of the 21st century, chiefly in an unregistered and unregulated form (Semigina & Karkach, 2021).

The existing problems of public senior-care infrastructure have not been addressed to date. Despite a relatively stable number of older people in absolute terms and their proportional increase within the population, there has been a persistent decline in public care provision for older persons. This trend intensified after 2014, when the war in Eastern Ukraine accelerated the socioeconomic crisis and demographic decline. The former triggered neoliberal anti-crisis austerity measures, including cuts in funding and personnel in the public sector. Social workers were among those laid off (Dutchak, 2018). This shift was accompanied by forced population displacement, with older people among the most vulnerable (Kuznetsova & Mikheieva, 2020; Kuznetsova et al., 2018; Mikheieva & Kuznetsova, 2023).

We interpret the fact that the first comprehensive reform in care for older people took place 29 years after Ukraine's independence as demonstrating the lack of political priority assigned to senior care. The reform marked a further move toward a more targeted, cofunded, and decentralized approach to provision and financing, wherein all social services were expected to operate according to quasimarket principles with various providers competing for public funding (Dutchak, 2024; Lomonosova, 2021). Although its implementation was cut short by Russia's full-scale invasion, the reform set up existing trajectories of decentralization, marketization, and fragmentation in public care provision for older people (Semigina & Karkach, 2022).

There is very limited financial support for family carers in Ukraine. With the 2020 reform, the government introduced "compensation for nonprofessional or professional care," for which family carers can apply (Supreme Council of Ukraine, 2019). According to the data we requested, approximately 35,000 people receive "compensation for nonprofessional care," amounting to an average of UAH 2,500 (55 euros as of September 2024) per month, while approximately 770 people receive "compensation for professional care," with an average of UAH 8,300 (180 euros) per month. The latter can be obtained if a person completes a training program and registers as a self-employed social services provider. As is evident, support for those providing nonprofessional care to family members is scant, and only a very small number of people receive the higher professional compensation; in some regions, there are no recipients at all. Notably, in response to our request for information, the administration of one such region stated that this payment is not provided "due to lack of any need." We interpret this as indicating that the support is perceived as too limited to justify the effort required to apply, or that authorities do not promote organizing training and informing people about this program.

Earlier research (Bezrukov, 2003; Bezrukov & Verzhikovskaya, 1994) concluded that the family-based model of care for older persons established during the Soviet period could not continue to dominate under the rapidly changing socioeconomic and demographic conditions (Gutterman, 2022; Slyusar, 2022). In the following decades, recurring scandals emerged around conditions in chronically underfinanced and understaffed public facilities, while private facilities remained largely inaccessible and unregulated (Dutchak, 2024; Tkalich et al., 2025). Family-based care provision also remained the overwhelmingly preferred model among older people themselves: 55.4% stated that care is the obligation of children or relatives (Ukrainian National Academy of Science & Institute of Demographic and Social Research, 2014, p. 250), and 75% expressed negative attitudes toward residential care, including 40% who considered it the worst thing that could happen in old age (p. 258). Given the existing situation in the senior-care sector, population resources, and prevailing attitudes, it is unsurprising that only 2% of older people with care needs in their family use public or private residential care, only 3% regularly use paid carers' support, and 10% use it occasionally

(Strelnyk, 2026). Overall, we conclude that the deprioritization of care for older people and resulting fragmentation lead to the family—and overwhelmingly women—remaining the main pillar of the senior care regime in Ukraine.

2.2. War as Disrupting the Care Landscape and Networks of Support

Russia's full-scale invasion in 2022 brought destruction, a severe economic crisis, and forced population displacement, radically impacting all parts of the social fabric of Ukrainian society. The prolonged war resulted in the destruction of care infrastructure, including damage to and destruction of at least 159 social services facilities (Cabinet of Ministers of Ukraine, 2024), and the killing and injuring of both older people and care workers. With the rapid advance of the Russian offensive at the beginning of the invasion, the authorities failed to evacuate a number of public residential care facilities, some of which ended up under occupation while others found themselves on or near the frontline under heavy shelling (Lomonosova & Babych, 2022). More broadly, safety in public care infrastructure for older adults—including the availability of shelters and their actual use during air raid alarms—has attracted little public, political, or policy attention, especially when compared to other domains of care infrastructure, such as schools and hospitals (Dutchak, in press). A lack of electricity, heating, water, and access to basic medical care further devastated the lives of older people in need of care and basic stability in their old age, often overlooked by both the Ukrainian and international public.

Destruction, danger, and the priorities of the defense economy have all contributed to shrinking care provision for older people and placed additional pressure on existing infrastructure (Amnesty International, 2023; Lomonosova & Babych, 2022). The massive population displacement caused by the invasion further exacerbated this pressure, as host communities are required to accommodate the care needs of growing numbers of older persons and others in need of care. Moreover, existing public residential care facilities—however problematic their conditions—are often the only places on which volunteers can rely to house certain older people, especially those with restricted mobility. While the official policy of deinstitutionalization has been promoted in the context of EU accession, paradoxically, some local NGOs supported by foreign donors and involved in the evacuation of older people have been creating additional places in public residential care facilities, thus expanding their capacity. As one NGO representative explained during an interview, "hampering the creation of new places in geriatric institutions is tantamount to not evacuating these people."

The large-scale population displacement triggered by war has also disrupted existing kinship and other informal networks, which, as described in Section 2.1, traditionally play a major role in family care (Dutchak, 2023; Slyusar, 2022). Older persons are among those least inclined to leave—either abroad or to safer territories within Ukraine—for a variety of personal and structural reasons. As a result, they are often those who "stay behind," but they are also sometimes separated from other family members during evacuation processes because there are fewer opportunities for them to find temporary or permanent accommodation capable of meeting their needs in cases of restricted mobility or intensive care requirements (Amnesty International, 2023).

The breakdown of informal networks has also resulted in a growing number of older people in need of external care provision. This, in turn, increases the workload of visiting care workers, especially in frontline

communities, but also in those hosting substantial numbers of internally displaced people (Amnesty International, 2023; Lomonosova & Babych, 2022). Despite workloads that are sometimes twice the norm, and despite working conditions marked by air raid alarms, shelling, and power cuts, social workers continue to receive low wages, often close to the minimum (Lomonosova, 2024). Amid existing policies and historical developments, public care for older people in Ukraine rests mostly on the undervalued labor of public care workers. This labor is framed as disposable and is retained within the sector through structural factors and the exploitation of gendered affective expectations associated with care (Dutchak et al., in press). These workers, mostly women who are often themselves close to retirement age, continue to provide some level of public care to the most vulnerable older persons, including in war-endangered territories.

Since 2022, substantial resources have been mobilized within civil society—both domestically and internationally—to provide humanitarian relief and other forms of support to various groups in Ukraine. The local NGOs and volunteers whom we interviewed, and who seek to mobilize resources within Ukrainian society to support public residential facilities or advocate for improvements in public provision, reported that they were forced to shift to purely humanitarian assistance in 2022, as needs became urgent amid the invasion. One NGO representative supporting public residential facilities identified the war as a key factor contributing to the further invisibilization of old age in public discourse:

> Those who die in war cannot be old a priori, because they die young. So the war has changed our attitude toward old age—we care even less about older people….Now it is even more difficult to collect money for [their needs].

Another volunteer explicitly described how difficult it is to fundraise in Ukraine for senior care compared to causes such as children's welfare. Referring to a dialogue with potential patrons, she recalled: "They said…'you are dealing with an unpromising sector.' I said, 'My apologies, but in decades to come, you will become that 'unpromising sector.'"

Our research points to the key role of (often externally supported) local NGOs and volunteers in the evacuation and, to some extent, the placement of older people, especially during the first months of the invasion, when the situation with official evacuations was described as "catastrophic" by one NGO representative. There are, however, structural limitations to the provision of meaningful support for older people, and these limitations are embedded in both international humanitarian approaches and Ukrainian social policy. International humanitarian projects are typically limited in funding duration, and so Ukrainian authorities may be reluctant to step in. In an interview, a worker from a large international charity organization described a situation in which they were opening a shelter for displaced older people in a community, and the local authorities explicitly told them, "Just make sure that these people are not left in our care and funding later." Overall, while local nonprofit actors have limited internal resources, international projects—given their current design and funding architecture—are poorly equipped to address the situation for older people, whose need for support tends to increase rather than decrease over time. In other words, short-term grant schemes that last a few months or a year do very little to resolve this situation. Moreover, there are very few nonprofit actors involved in residential care, which may be the only viable solution for displaced older persons with care needs in a context where social housing is virtually absent.

Since the invasion began, many older people have been left without adequate care (Amnesty International, 2023; Dutchak, 2024; Gutterman, 2022). In 2025, 36% of people in Ukraine had an older family member who

required regular care of varying intensity, while 24% had such a person in recent years (Strelnyk, 2026). When combined with shrinking family access to private care options amid an economic downturn, this has resulted in widening gaps in care for older persons that must be managed within families.

This situation has also produced a widening gender gap. Data show that women in Ukraine are more involved in care for older persons within families (Strelnyk, 2026): Approximately every third woman and every fourth man has some experience of providing care for older persons, while approximately every fourth woman and every sixth man has experience of intensive care provision for older people on a daily or almost daily basis. While responses to questions about preferred carer gender highlight the role of stereotypes, Olena Strelnyk (2026) also points to longer female life expectancy, wage inequality, work schedules, and prior care experience as contributing factors.

Yet, such a widespread experience has attracted little research attention. In Ukraine, where the problems faced by older people in need of care have never been significantly present on the political agenda or in public debate (Dutchak, in press), the growing urgency of this problem fades in light of the war and the prospects of a postwar future shaped by rapid demographic change. Today, older people are the only demographic group whose absolute numbers have not declined significantly, while their proportion in the overall population has increased dramatically over the past few years. While the family remains the main pillar of care for older persons in Ukraine, to understand the impact of the fragmented care landscape at the bottom of care hierarchies, it is first essential to disentangle the black box of "family care."

3. In-Family Care Arrangements: Networks and Carers

In this context, we now turn to an empirical discussion of how families arrange care for their older members at the bottom of care hierarchies within a fragmented and poorly accessible support and public infrastructure. We follow how some families find, organize, and combine multiple forms of care provision, including kinship-based, public, private, and charitable options. Through this mosaic of arrangements and experiences, we piece together the puzzle of fragmented care options and analyze how families navigate them to make care arrangements for older people work despite the decades-long neglect of the sector.

3.1. Central Actors and the Gendered Nature of Care Arrangements

Maryna (all names changed to preserve anonymity) is a social educator. She is slightly over 70 years old and lives in a city with her mother, whose health has been steadily deteriorating and who has used a wheelchair for several years. In addition, her mother has hearing problems and early-stage dementia. Maryna's husband suffered a stroke a couple of years ago and has been bedridden since then. While Maryna is the main carer for both her mother and husband, other family members—and even a friend—have been involved occasionally at different stages. Her sons regularly help bathe their father. Meanwhile, they, along with her daughter-in-law, granddaughter, and friend, stay at home from time to time when Maryna has to go to work or when she very occasionally goes on a retreat for a few days. A couple of months ago, with financial support from her sons, Maryna hired a visiting carer through a private agency. The carer comes for six hours two to three times per week to perform hygienic procedures for both Maryna's mother and husband and to manage some basic housework. While the carer is present, Maryna goes out to meet friends, watch a movie, or simply take a walk in the park.

Maryna's situation is fairly typical for long-term senior care, as captured in our research. The initial arrangement of one main carer seems to be the only possibility for the majority of families within the fragmented care landscape and amid the general socioeconomic situation: Some have to earn a living while another person performs the unpaid labor of care. These widespread arrangements are explicitly gendered. Maryna's role as the main carer was never discussed and emerged seemingly naturally, as she was living in the same apartment as her mother and husband and had a relatively flexible working schedule. Although she has a brother, she did not discuss this issue with him, explaining that her role as the main carer came "by default, without saying." Gender inequality in the distribution of care responsibilities is well documented, including recently in Ukraine (Strelnyk, 2026), as mentioned above, and women represent between 57% and 81% of in-family carers, depending on the country (Sharma et al., 2016).

We encountered other cases in which a daughter is the main carer for one or both parents while a son provides material support and engages directly in care only occasionally. The women in our research explained it as something that happened without a clear reason: "Somehow [this arrangement] happened between us, just like that." In all such cases we encountered, there were specific circumstances behind these decisions: A son works full time out of town; he has his own family unlike his sister, or, as in Maryna's case, she was already living in the same household as relatives with care needs. The circumstantial nature of main-carer selection within families is particularly visible in a rarer care arrangement described by another research participant, Kateryna. She lives in a village with her husband and her bedridden father-in-law, who has dementia. A few years ago, while her father-in-law was still living separately, she regularly visited him to help manage his care; when she started a job and her husband lost his, he became the main carer.

While families make circumstantial choices about who will be the main carer in the context of the existing gender inequality, these duties often fall on women. And while there is a rationale behind it for the families, this does not mean that the role of main carer fits seamlessly into a person's life, nor does it imply that in all cases it is taken for granted, without complaints or resentment (as also documented by Strelnyk, 2026). A decision conditioned by preexisting circumstances does not mean that the main carer does not have to make sacrifices—quite the contrary. In many cases, her entire life has to be reorganized around this responsibility. While care for older persons is often a highly demanding task within families, a circumstantial choice of care arrangements, as our research shows, can hardly be described as "the easiest one"; rather, it is often the only possible option within a given family situation that unfolds within a fragmented care landscape.

While gender-imbalanced patterns of in-family care arrangements prevail both statistically and in our research, there are also cases—fewer, but clearly present—where a son becomes the main carer among siblings. We encountered such a case in our fieldwork with Viktor caring for his father. When the previous primary carer—his mother—died, his sister stated that "she does not want to take care of him" and suggested that Viktor either step in or that they jointly hire a carer. After calculating the costs and again taking circumstances into account, Viktor opted for the first solution. Having a small child and having lost his job because of the war-induced crisis, he moved with his family into his father's apartment to become the main carer. We can cautiously assume that the number of such cases may further increase, as the status of main carer is one of the grounds that men in Ukraine can use to defer their war mobilization. Although Viktor did not identify this as a key reason in his decision, he demonstrated extensive knowledge of relevant mobilization legislation, clearly following legal changes and expressing concern about them.

As in Viktor's case, in-family care is often initially provided primarily by a spouse—if they are present and relatively healthy—and later "passed on" to children when this arrangement is no longer possible. This was also evident in Lilia's story. After her mother suffered a stroke several years ago, her father became the main carer, supported by Lilia and her sister in physically demanding tasks such as bathing, while a visiting carer provided by an ethnic organization regularly managed housework. After Lilia's father died of Covid-19, Lilia and her sister negotiated a less typical care arrangement, essentially providing care in shifts: For several months, Lilia and her husband lived with their mother, followed by several months during which her sister took their mother into her home. As Lilia explains, "you could somehow live like that for six months—you do it hard for six months, and then you somehow recover for six months."

3.2. Support Networks and the Effects of War

There is another common pattern present in Maryna's story and in most cases we encountered: the mobilization of family and other personal networks to support the main carer. These may include relatives living in the same household and providing regular assistance, or those living separately (even in another city or country), who step in occasionally. For example, while Lilia was the main carer during her shift, working from home since the pandemic began, her husband regularly supported her, and her nephew could stay with her mother for a day or two if both Lilia and her husband needed to leave the city. Similar arrangements were present in Viktor's case. While his sister refused the role of main carer, she would occasionally step in when he needed to leave the city.

Beyond relatives, friends and neighbors also step in, usually to check on an older person when the main carer has to be absent for a short period, ensuring that the person is well, has taken medication, or has eaten. However brief and scattered such support may be, these nonkinship ties are particularly important when there are no relatives to rely on. Svitlana's story provides one such example. Her family became displaced after the war in Eastern Ukraine began in 2014, and her mother lives separately but in the same apartment building. To manage care during business trips, Svitlana relies on reciprocal support with her neighbor:

> If I'm at home and [my neighbor] is not, I look after her mother. I can jump in, bring her something, help. And if mine feels bad, and I'm not there, and [my neighbor] is at home, then [she] can help. Sort of—we don't have any relatives.

Svitlana's story also illustrates the complexity of in-family care needs and arrangements. This complexity is amplified by war, with the attendant displacement disrupting informal networks and challenging families' ability to establish new networks to meet care obligations. While Svitlana cares for her mother, her mother is still able to support the woman with childcare for two children, one of whom has special needs. In addition, the family manages distance-based support for Svitlana's in-laws, paying their neighbors in the village to keep an eye on them. Since their in-laws would not accept paid help (for example, checking on them, bringing groceries, and assisting with household chores), Svitlana has to pay the neighbors secretly, presenting it to the in-laws as neighborly help. When Svitlana's husband joined the army at the beginning of Russia's invasion, all these care responsibilities were coordinated and managed by her. Later, when he returned to civilian life, she also had to care for him during a period of rehabilitation and adaptation.

Another telling example is the story of Natalia, who left Ukraine with both her parents in search of safety abroad. Although her brother provides material support in the host country, where he has lived for several years, Natalia finds herself almost completely isolated with two older relatives in need of care. Her mother developed severe depression due to war and displacement, and Natalia believes her father experienced a rapid progression of Parkinson's disease as a result of these catastrophic circumstances. While in Ukraine, as Natalia explains, many care-related tasks were done and organized "automatically": in a fragmented but familiar and relatively accessible landscape of care. In an unfamiliar setting, without time for socialization and unable to access any form of care support, she experiences both physical and psychological exhaustion, describing her situation as "impossible" and as "fighting tooth and nail." A similar loss of familiarity and understanding of how things work in a new place was expressed by an internally displaced woman in our research who cares for her mother. In contrast, in another case involving a refugee woman who moved with her mother to a country with relatively developed social provision, the experience was quite different: "in a sense," she explains, "moving to [this country] and access to [local] medicine was life-saving for her, that is, she simply would not have survived in Ukraine." Thus, while war-induced displacement almost invariably makes care for older people more difficult because of broken networks and the challenges of integration, the availability of institutional care support in host settings can make a decisive difference.

While the impact of war on in-family care arrangements is most visible in cases of forced displacement, we also encountered it in other narratives. Job losses, income declines, rising prices, and power outages represent just a few of the many daily, tangible consequences of the war. These factors not only greatly complicate care labor but also create life-threatening situations for both people receiving care and their carers. In all our research case studies, families reported not using proper shelters during air raid alarms. If their older relatives could walk, they would move them to a corridor with two walls separating them from the street; otherwise, they did nothing and hoped for the best. While minimizing precautions has become common practice after years of regular bombardment in Ukraine, in senior care contexts this is also objectively conditioned by older people's inability to move quickly or at all. As a result, a substantial part of war-related narratives centers on fear and the suppression of fear. Some research participants even expressed relief that older relatives with hearing impairments are spared some stress, being unable to hear air raid sirens or distant explosions. For instance, Marina speaks about her fear and inability to imagine what she would do if their house caught fire during shelling, given that two relatives with limited mobility live there. Ultimately, she concludes: "I sometimes think about it, but then I push these thoughts away because they are destructive. I can't change anything."

Overall, the gendered nature of in-family care for older persons is shaped both by stereotypes and by personal circumstances—circumstances that are themselves often gendered. Women live longer. They are more likely to have prior experience with care and housework; they work flexible or part-time jobs more frequently, and thus tend to have more perceived space to absorb responsibilities of care for older persons and reorganize their lives around them, particularly when care is transferred from an often-retired spouse to working-age children. The one-main-carer model has a profound impact on carers' lives and on their mental and physical health; care needs are often so intensive that no single person's time or flexibility is sufficient. In such cases, and for more general reasons, informal networks within and beyond the extended family are commonly mobilized to support the main carer. In some situations, however, there are few or no networks or alternatives to rely on. While this can occur for various reasons, the war has caused radical disruptions to institutions and kinship and local networks, destroying them or intensifying their fragmentation (Dutchak, 2024), leaving individuals who provide long-term care even more overburdened and isolated.

4. Beyond Informal Reciprocity: A Gray Zone of Options

4.1. The Limits of Institutional Care

As Maryna's and Lilia's examples demonstrate, the intensity of care for older persons pushes families to seek regular external support beyond occasional, predominantly kinship, and reciprocity-based networks. As discussed in the previous sections, the marginal positioning of care for older people within care hierarchies has resulted in sustained political neglect and, consequently, in scant, fragmented, and weakly regulated provision. Families' options also depend strongly on available resources, especially financial ones, though social resources matter too. We observed that more accessible public care has become increasingly targeted, understaffed, and underfinanced because of neoliberal reforms, a reorientation to the defense economy, and war-related disruptions.

We encountered only fragments of public care during fieldwork. Families may receive some hygienic products, a wheelchair, or a voucher for a short rehabilitation stay. In other cases, a public social worker visits twice a week alongside hired carers, or a mobile palliative brigade visits occasionally, sometimes offering temporary admission to a hospital facility. Often, however, conditions in such facilities are so poor that families refuse these offers. While this scarcity may partly reflect our research focus on family arrangements, and the relative weight of public provisioning can be more substantial in the cases of lonely older persons, our research nevertheless indicates the general lack and fragmented state of public provisioning because of decades of policy neglect.

Private residential care appeared only in a few cases and remained an option for very few. As Viktor put it, "[Private] institutions are very expensive." Cultural norms further reinforce care choices: For many older people, institutional care is unacceptable. As Maryna explains, "it would be a trauma for my mother…care should be undertaken at home." Thus, families are often predisposed against opting for residential care. Public options are rejected because of poor conditions at the facilities, whereas private options are mistrusted because of informality or conflicting cultural attitudes. As Tetiana, who cares for her grandmother, explained: "I rejected this option because I understand that no one will treat her with such love." Such refusals are tied to feelings of indebtedness and the desire to spend their remaining time together, but they may also be conditioned by the gendered affections attached to care, described elsewhere as part of the care-labor disposability construction (Dutchak et al., in press).

Nevertheless, several families in our research did choose private residential care. Uliana, living abroad, placed her father in a private facility after her stepmother could no longer care for him. Her father's progressing dementia made continued home care impossible, and Uliana describes the situation as one that her stepmother "had to quit…to save herself." Living abroad often enables families to afford such care, especially when intensive, round-the-clock support is required, as is common with progressive neurodegenerative diseases.

This dynamic is visible in Larysa's story of caring for her mother with Parkinson's: "The situation reached a stage where family help turned out to be insufficient. It was not qualified enough; it was not rational in terms of how everyone was involved." Initially rotating care between siblings, Larysa was soon exhausted and searched for a live-in carer unsuccessfully. Eventually, they placed their mother in a private facility.

When Russia's full-scale invasion commenced, Larysa began working abroad, and her brother joined the army. She explains:

> If before it was a question of saving our psyche and making sure that mother received proper care, now it is a physical necessity…even if we imagined that we wanted to break down and sacrifice ourselves, it is now physically impossible [for us to care for her].

In the cases of private residential care arrangements encountered in our research, the informality of the field has a strong impact on families. Families navigate their choices half blind, relying on internet reviews, experiences of people they know, and impressions from short personal visits. Uliana, who visited every facility she could find in her home region, states that she was "choosing the best from the worst," while another research participant described her impression of one network of private facilities as "gangsters." Although families eventually found relatively suitable options, in all cases there were discrepancies between what was promised and what materialized. Unnegotiated changes in conditions also occurred, and these usually reflected the facilities' attempts to increase profit, for example, by accommodating more people in the same space, raising prices, or cutting services that were previously provided or promised. We conclude that while families' low income explains limited access to private facilities, most of their limitations and problems stem from decades of no coherent attempts to regulate this "unpromising" field, resulting in informality and a lack of standards, control, and transparency.

4.2. Visiting Care Options and Access

While private residential care is inaccessible to the vast majority of the population, private visiting care is far more widespread. As a continuum ranging from occasional visits to 24–7 shifts, it offers a variety of options for families with different resources. It is also more culturally acceptable for both older persons and their families, as the person remains at home, in a familiar setting, usually supervised or partially cared for by family members (if the visiting carer works part-time).

In some cases, families reject outsourcing care, even in the form of private visits. For Viktor, the main carer for his father, this was a matter of financial calculation: With one breadwinner earning an average wage, hiring visiting care could mean giving away the entire income. In Tetiana's case of caring for her grandmother, this refusal is narrated through a strong sense of personal obligation and the conviction that no one can do this work better than a family member. In other examples, older relatives strongly reject the presence of "strangers" in their home, especially for bodily care, as with the case of Lilia's mother who "wouldn't let a stranger touch her" and only accepted outside help for housework. This can go so far that families hire a carer or pay acquaintances while presenting them as friends, neighbors, or public social workers visiting for free. As one woman explains, "If [my mother] had known [that I'm paying them], she wouldn't have let them on her doorstep." This reflects a strong cultural belief that care cannot be paid for but must come from kinship, personal networks, or, in extreme situations, public home-based social care.

This combination of factors—cultural attitudes, personal relations, and a lack of material resources—can prevent people from hiring carers. Our research also shows that the influence of cultural attitudes and personal convictions may weaken over time and change as a person's health deteriorates, particularly in cases of neurodegenerative diseases.

As with private residential facilities, those who have the means to hire a carer and consider this an acceptable arrangement must search within a fragmented, largely informal, and unregulated field. In several cases, including Maryna's, carers were found through private agencies. People usually learned about these or recommended them through personal networks. In other cases, personal networks and social resources were used to find individual workers by asking relatives, friends, and acquaintances. Beyond more conventional visiting-care arrangements, we also encountered carers provided free of charge by an ethnic community organization, as in Lilia's story. Occasionally, as with Svitlana's in-laws, families pay a neighbor or acquaintance to fetch groceries, cook, or simply check on older relatives.

Reliance on informal networks and personal experience to find visiting caregivers or even basic information about agencies results from the informality and fragmentation of private senior care and its marginalized, privatized character. As care is pushed out of the public domain, the field is accessed and navigated primarily through personal and informal connections. Information scarcity is so severe that, as one woman told us, she has been asked for carer references ever since she hired one for her mother, even though her mother died seven years ago. This illustrates both the constant demand for such services and the persistent lack and stagnation of available options.

This finding is reflected not only in service users' experiences but also in those of care workers interviewed for this project. In the predominantly informal and weakly regulated field of private visiting care, with limited formal professionalization, personal recommendations play a central role. Common career trajectories in the sector also shape informal benchmarks of professional standards. Given the low wages in public healthcare and social services, workers from these sectors—nurses, junior medical staff, social workers—often become part- or full-time caregivers in private residential settings or in visiting care. In other cases, beyond personal recommendations, participants relied on workers' prior experience, either having worked in visiting care before or having family experience caring for older people or people with disabilities. Structurally gendered, like the senior care labor market itself, this "lived experience" is frequently considered a sufficient qualification for general cases of care for older people.

In our research, there were also families that had virtually no resources to support or outsource in-family care. Here, we highlight the rural–urban divide in access to out-of-family care options quantitatively documented in research (Strelnyk, 2026), but also other divisions including geographical and structural spaces where social reproduction becomes depleted because of war and neoliberal austerity (Dutchak, 2024). In Kateryna's case, where first she and now her husband care for his bedridden father with dementia, there are hardly any options in their village, particularly for a one-income household. Although during the interview she repeatedly said that she could not imagine alternative arrangements because "it's a family matter," she later explained: "I can't imagine it, because it just so happened in my life that in my 40 years there weren't all these different opportunities, and I just haven't seen anything like that, and that's why I can't imagine it."

5. Conclusions: A Fragmented Continuum of Care

Long-term care for older people lies at the bottom of care hierarchies and has been underfunded, underdeveloped, and fragmented in Ukraine for many years, because of both preindependence and postindependence policies in this "unpromising" domain. Over the years, these policies have resulted in a

familialistic model of care for older people dominant in society. The war has exacerbated these chronic problems, destroying public and private infrastructure and disrupting informal networks of reciprocity and support that have long compensated for institutional gaps.

The family-based model of senior care is sustained not only because alternative options are underdeveloped, but also because gendered cultural norms naturalize care as women's responsibility. As a result, and in line with how life courses are understood in Ukraine, care is carried out predominantly by middle-aged and older women—both within families and in paid care professions. This reinforces the structural invisibilization and devaluation of care labor. This becomes more intense when it intersects with ageism, gender inequality, and neoliberal labor market arrangements.

Overall, our research conceptualizes care arrangements for older people in Ukraine as a dynamic continuum of fragmented options rather than as distinct or stable care regimes. The boundaries between in-family reciprocity, informal personal networks, public services, and private residential and visiting care are shifting and often blurred. Long-term neoliberal austerity and the disruptive effects of war have further cemented senior care's position at the bottom of care hierarchies, leaving the familialistic model to dominate and producing a poorly regulated and increasingly fragmented care landscape in which families are compelled to continually reassess and recombine arrangements under changing conditions. In this context, care is not organized through clear pathways but through ad hoc navigation across fragmented and unevenly accessible options. Care arrangements, therefore, remain circumstantial, unstable, and unevenly distributed across households.

In some cases, families deliberately choose in-family care arrangements due to financial constraints, moral convictions, or distrust of existing external options. While such choices place significant burdens on main carers, they can also function as counterfragmentation strategies in a context where external care infrastructures are scarce, unreliable, or inaccessible. These individualized acts of stabilization, however, remain embedded in and reproduced through the familialistic model, rather than challenging it structurally. Fragmentation is further amplified by public and market-based care options, access to which is highly unequal and increasingly shaped by war-related destruction, displacement, and socioeconomic crisis. Our findings reveal a wide variety of care combinations: from reliance on kin networks to rotational arrangements, hybrid family-public solutions, and diverse monetized practices. Importantly, the chronic underfunding of public care institutions feeds into privatized arrangements—through supplying care workers to the private market, functioning as informal recruitment platforms, or creating conditions of scarcity that generate demand for private care.

Reliance on informal reciprocity and informalized paid care creates a fragile ecology of care relations, which war destabilizes even further. While this escalation in the care crisis is predictable, it remains largely absent from policy agendas and postwar imaginaries. The unchallenged neoliberal austerity risks deepening the marginalization of this "unpromising" sector through further marketization and privatization. In such a landscape, care for older people remains familialized and politically invisibilized, leaving older people dependent on relatives and families left to manage, negotiate, and patch together fragmented care arrangements.

Acknowledgments

We express gratitude to the research participants who shared with us their experiences of caring for older relatives. We are grateful to Andrew Hodges for proofreading the text.

Funding

This work was supported by the Volkswagen Foundation within the program Challenges and Potentials for Europe.

Conflict of Interests

The authors declare no conflict of interest. In this article, editorial decisions were undertaken by Ulf R. Hedetoft (University of Copenhagen).

Data Availability

The ethnographic data on which this study is based are confidential and cannot be shared in accordance with research ethics commitments made to participants.

LLMs Disclosure

ChatGPT (GPT-4) was used to improve the text's grammar.

References

Amnesty International. (2023). *"They live in the dark." Older people's isolation and inadequate access to housing amid Russia's invasion of Ukraine*. https://www.amnesty.org/en/documents/eur50/7385/2023/en

Bennholdt-Thomsen, V., & Mies, M. (2000). *Subsistence perspective*. Zed Books.

Bezrukov, V. (2003). Case-study Ukraine. In J. Brodsky, J. Habib, & M. Hirschfeld (Eds.), *Long-term care in developing countries ten case-studies* (pp. 3–37). World Health Organization.

Bezrukov, V., & Verzhikovskaya, N. (1994). Status report from Ukraine. *Ageing International*, *21*(3), 54–61. https://doi.org/10.1007/BF02681226

Cabinet of Ministers of Ukraine. (2024). *Stratehia demohrafichnoho rozvytku Ukrainy na period do 2040 roku*. https://zakon.rada.gov.ua/laws/show/922-2024-%D1%80#Text

Dutchak, O. (2018). *Crisis, war and austerity: Devaluation of female labor and retreating of the state*. Rosa Luxemburg Stiftung.

Dutchak, O. (2023, January 18). Together we stand: Enforced single motherhood and Ukrainian refugees' care networks. *Spilne/Commons*. https://commons.com.ua/en/u-yednosti-sila-vimushene-samotnye-materinstvo-ta-merezhi-doglyadovoyi-pidtrimki-ukrayinskih-bizhenok

Dutchak, O. (2024). Caring for Ukraine: Care and social reproduction in wartime Ukraine. *Transform Review: European Review of Politics*, *1*, 66–85.

Dutchak, O. (in press). Hierarchies of care in Ukraine: Neoliberal reforms, fragmented labor and the war. In K. Krulišová, M. O'Sullivan, A. T. R. Wibben (Eds.), *Re-thinking feminist perspectives on war, peace and (in)security*. Manuscript submitted for publication.

Dutchak, O., Lomonova, T., & Tkalich, O. (in press). Social reproduction and care workers in Ukraine in the times of austerity and war: Construction of disposability and exploitation of love. *Praktyka Teoretyczna*.

Günel, G., & Watanabe, C. (2024). Patchwork ethnography. *American Ethnologist*, *51*(1), 131–139. https://doi.org/10.1111/amet.13243

Gutterman, A. (2022). *Older people and the crisis in Ukraine*. SSRN. http://doi.org/10.2139/ssrn.4092078

Kuznetsova, I., & Mikheieva, O. (2020). Forced displacement from Ukraine's war-torn territories: Intersectionality and power geometry. *Nationalities Papers*, *48*(4), 690–706. https://doi.org/10.1017/nps.2020.34

Kuznetsova, I., Mikheieva, O., Gulyieva, G., Dragneva, R., & Mykhnenko, V. (2018). *The social consequences of population displacement in Ukraine: The risks of marginalization and social exclusion* (Policy brief No. 13). The University of Birmingham. https://doi.org/10.5281/zenodo.1217838

Lomonosova, N. (2021, November 30). Yak optymizuvaly turbotu: Filosofia ta praktyka reform sotsialnykh posluh. *Spilne/Commons*. https://commons.com.ua/uk/yak-optimizuvali-turbotu-filosofiya-ta-praktika-reformi-socialnih-poslug

Lomonosova, N. (2024). *"They are waiting for us": The impact of the full-scale war on the working conditions of social workers*. Cedos. https://cedos.org.ua/en/researches/voni-chekayut-na-nas-vpliv-povnomasshtabno%D1%97-vijni-na-umovi-praczi-soczialnih-praczivni_cz

Lomonosova, N., & Babych, K. (2022). *Sotsialnyi zakhyst i viyna v Ukraini (24 liutoho—30 kvitnia)*. Cedos. https://cedos.org.ua/researches/soczialnyj-zahyst-i-vijna-v-ukrayini-24-lyutogo-30-kvitnya-2022

Mikheieva, O., & Kuznetsova, I. (2023). *Internally displaced and immobile people in Ukraine between 2014 and 2022: Older age and disabilities as factors of vulnerability*. International Organization for Migration. https://publications.iom.int/system/files/pdf/pub2023-031-r-mrs77-internally-displaced.pdf

Palley, H. A., & Romanenkova, L. A. (2004). Long-term care policy for the elderly in the Zaporozhye region of Ukraine: A case study of social development following the collapse of Communism. *Journal of Aging & Social Policy*, *16*(3), 71–91. https://doi.org/10.1300/J031v16n03_05

Semigina, T., & Karkach, A. (2021). *The elderly care, active ageing and geragogy: Could they co-exist in Ukraine and how*. SSRN. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4303768

Semigina, T., & Karkach, A. (2022). Elderly care in greying Ukraine: Challenges and prospective. In R. Baikady S. M. Sajid, J. Przeperski, V. Nadesan, M. Rezaul Islam, & J. Gao (Eds.), *The Palgrave handbook of global social problems* (pp. 1–17). Palgrave Macmillan.

Sharma, N., Chakrabarti, S., & Grover, S. (2016). Gender differences in caregiving among family-caregivers of people with mental illnesses. *World Journal of Psychiatry*, *6*(1), 7–17. http://doi.org/10.5498/wjp.v6.i1.7

Slyusar, L. (2022). Ukrainian family in the conditions of war and forced migration. *Creşterea economică în condiţiile globalizării*, *16*, 57–64.

Strelnyk, O. (2026, January 29). "Mama sto vidsotkiv na meni": Simeine pikluvannia pro liudei starshoho viku v hendernomu i klasovomu vymirakh. *Spilne/Commons*. https://commons.com.ua/uk/simeine-pikluvannia-pro-liudei-starshoho-viku

Supreme Council of Ukraine. (2019). *Law of Ukraine "On social services."*

Tkalich, O., Dutchak, O., & Lomonosova, N. (2025). *One for three: How Ukrainian nurses work during the war*. Medical Movement "Be Like We Are." https://www.medryh.com.ua/wp-content/uploads/2025/04/eng-nurses-online.pdf

Ukrainian National Academy of Science, & Institute of Demographic and Social Research. (2014). *Naselennia Ukrainy: Imperatyvy demohrafichnoho starinnia*. ADEF-Ukraina. https://www.idss.org.ua/monografii/2014_Naselennya.pdf

Vogel, L. (2000). Domestic labor revisited. *Science & Society*, *64*(2), 151–170. https://doi.org/10.1177/003682370006400202

About the Authors



Oksana Dutchak holds a PhD in sociology from the Kyiv Polytechnic Institute. Her research focuses on social reproduction, gender inequality, care labor, and care migration. She is devoted to engaged research, which contributes to public discussion and policies, trying to give a voice to workers and other structurally underprivileged groups.



Olena Fedyuk holds a PhD in social anthropology from Central European University. Her research focuses on transnational labour migration, gendered work, labour sourcing agencies, and migrant workers' rights through action research. She is interested in feminist-informed research methodologies and has developed expertise in qualitative and visual methods, including documentary filmmaking.



Anna Oksiutovych is a social researcher with a background in feminist activism and informal education. Her areas of interest and research include labor rights, youth work, gender and migration, and childhood during war.

Social Inclusion
2026 • Volume 14 • Article 12191
https://doi.org/10.17645/si.12191

cogitatio

ARTICLE

Open Access Journal

Bounded Transport, Mobility Justice, and Claims for Recognition Among Live-in Care Workers

Petra Ezzeddine

Department of Social and Cultural Anthropology, Faculty of Humanities, Charles University, Czech Republic

Correspondence: Petra Ezzeddine (petra.ezzeddine@fhs.cuni.cz)

Submitted: 13 February 2026 **Accepted:** 15 July 2026 **Published:** 3 September 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

European long-term care systems increasingly depend on regularly commuting live-in care workers from Central and Eastern Europe, yet the mobility infrastructures sustaining this labour remain largely overlooked. This article examines bounded transport, an emic term used by Slovak live-in care workers, brokerage agencies, and transport providers to describe agency-organised door-to-door transport between workers' homes and care recipients in Austria. It argues that bounded transport constitutes a critical yet invisible infrastructure of transnational care, organising labour mobility while redistributing temporal, financial, and bodily risks. Drawing on policy analysis, online ethnography, advocacy materials, and semi-structured interviews, the article demonstrates how repeated fatal transport accidents transformed an ordinary feature of cross-border care into a site of social contestation and collective action. By conceptualising mobility as an integral component of care rather than its external condition, the article contributes to debates on long-term care governance and mobility justice by showing how live-in care workers transform experiences of invisibility and vulnerability into claims for recognition and solidarity in the governance of European care regimes.

Keywords

Austria; collective action; European Union; live-in care; mobility justice; recognition; Slovakia; transport

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

We open with a quote by Júlia, representative of a live-in care workers' organisation in Austria:

> It is terrible, but this invisible work only becomes visible in society when some tragic transport accident happens. Yet every two weeks, thousands of women travel under quite unsafe conditions.

Senior care systems in the European Union, closely linked to the normative ideal of ageing in place and the provision of care within older people's home environments, have become increasingly dependent on cross-border care arrangements sustained by regularly commuting live-in care workers from Central and Eastern Europe to Western Europe (Katona & Melegh, 2020). These arrangements have become a central component of contemporary European care regimes, enabling older people to remain in their homes while relying on mobile care workers who circulate between sending and receiving countries.

According to Ezzeddine and Uhde (2025), such arrangements operate through specific "borderscapes of care": dynamic, socially and politically produced configurations that shape mobility, labour relations, and everyday practices of care. Within these borderscapes, care emerges as a paradoxical commodity, essential for sustaining life and social reproduction—yet socially devalued and precariously organised, with structural inequalities continuously produced across the European Union (pp. 401–402).

A growing body of research has documented the conditions of transnational care work, addressing receiving and sending contexts, as well as the consequences of migration for families and communities (for example, Aulenbacher et al., 2024; Bahna & Sekulová, 2019; Katona & Melegh, 2020). However, considerably less attention has been paid to the material and organisational infrastructures through which live-in care workers themselves are transported across EU borders within rotational care regimes.

Transport is not merely a logistical matter; it constitutes a critical infrastructure through which participation in transnational care labour markets is organised, governed, and differentiated (Sheller, 2018). Despite its centrality to the functioning of cross-border care, transport has remained largely absent from debates on long-term care governance, labour mobility, and social inclusion. This absence reflects not only a regulatory gap but also a form of institutional exclusion: workers who sustain European care systems remain largely absent from the governance frameworks that organise their mobility, working conditions, and everyday security.

Throughout this article, I use the term "bounded transport," a vernacular expression employed by Slovak live-in care workers in Austria, brokerage agencies, and transport providers to describe agency-organised door-to-door transport between workers' homes and the private households where they provide care. Rather than introducing a new analytical concept, I take this emic category seriously and examine what it reveals about the organisation of transnational live-in care. As used by actors themselves, bounded transport (*viazaná doprava* in Slovak) refers not simply to physical movement but to mobility arrangements embedded within employment relations through agency coordination, rotational schedules, reimbursement practices, and organisational dependency.

Although formally presented as a voluntary service, bounded transport frequently becomes a practical condition of employment, shaping workers' autonomy over how, when, and under what conditions they

travel. The apparent individual responsibility for mobility therefore conceals a broader infrastructure through which agencies, transport providers, and care markets coordinate the circulation of labour.

This article argues that bounded transport constitutes a critical yet largely invisible infrastructure of cross-border care migration in the European Union. Although indispensable to the functioning of rotational live-in care, it remains fragmented across labour law, transport regulation, and care policy, with no governance framework recognising mobility as an integral component of live-in care work. As a consequence, responsibility for organising and managing transport risks is largely shifted onto workers themselves. At the same time, the infrastructure underpinning Europe's ageing-in-place model remains weakly regulated and politically overlooked.

The article further argues that bounded transport reveals a paradox of contemporary European care regimes. Migrant care workers are economically included as essential providers of care, yet remain institutionally excluded from many of the regulatory and political processes through which their work and mobility are organised (Ezzeddine & Matiaško, 2026). By examining transport infrastructures, the article therefore moves beyond questions of movement alone and asks how inclusion and exclusion are produced through the everyday organisation of care mobility.

Drawing on policy analysis, online ethnography, semi-structured interviews, and advocacy materials, the article demonstrates how repeated transport accidents transformed what had long been treated as an ordinary feature of cross-border commuting into an object of social contestation. Fatal accidents exposed the hidden labour of mobility, the fragmented governance of cross-border care, and the unequal distribution of responsibility embedded in agency-organised transport. At the same time, they catalysed multiple forms of collective action, including policy advocacy, transnational organising, digital practices of remembrance and solidarity, and everyday collective efforts by live-in care workers themselves to make journeys safer.

This article asks three interrelated questions. First, how does bounded transport function as a critical infrastructure of transnational live-in care, and how do labour law, transport regulation, and care policy shape (or fail to govern) these mobility arrangements? Second, how do repeated transport accidents make visible the structural inequalities, regulatory fragmentation, and unequal distribution of responsibility embedded in cross-border care mobility? Third, how do live-in care workers transform bounded transport into a site of collective action through formal advocacy and everyday collective practices, and what do these forms of mobilisation reveal about the possibilities for recognition, participation, and social inclusion within European care regimes?

2. Theoretical Background: Bounded Transport as a Site of Social Contestation and Recognition

This article conceptualises bounded transport as the agency-organised, door-to-door mobility that connects live-in care workers' homes and workplaces, and structures the temporal and spatial organisation of rotational care. Far from being a neutral logistical service, bounded transport shapes access to employment, redistributes temporal, financial, and bodily risks, and conditions workers' everyday experiences of mobility. Transport therefore constitutes a critical infrastructure of transnational social reproduction.

While infrastructure studies have demonstrated how material systems and socio-technical assemblages organise everyday life (Buier, 2023; Larkin, 2013), this article shifts attention from infrastructure as a technical arrangement towards the social relations, inequalities, and political struggles that emerge through and around it (Xiang & Lindquist, 2014). Bounded transport is therefore approached not simply as a means of movement but as a social and political arrangement through which care labour is made possible.

Drawing on Polanyi's (1944/2001) concept of the double movement, bounded transport is understood as a site of social contestation generated by the expansion of market logics into care and mobility (see also Aulenbacher & Leiblfinger, 2019). As market-based forms of organising cross-border care increasingly commodify not only care labour but also the infrastructures through which labour circulates, new forms of vulnerability emerge. These processes simultaneously generate countermovements seeking to protect the social conditions of care.

Following Abraham and Aulenbacher (2019, p. 250), such responses can be understood as "progressive and emancipatory democratic countermovements" that challenge the marketisation of care through political advocacy, legal interventions, collective organising, and public claims-making. Rather than opposing mobility itself, these struggles contest the unequal distribution of risks and responsibilities embedded in the organisation of transnational care.

These struggles can also be understood as claims for recognition. Tronto's (1993, 2013) democratic ethics of care argues that democratic care depends on recognising care as a public responsibility and ensuring that those who provide and receive care are included in decisions about how it is organised and governed. From this perspective, care is not merely a private or interpersonal practice but a matter of democratic participation, responsibility, and public accountability (Matiaško, 2026).

Moreover, Hatton (2017) conceptualises invisible work (as care work is) as labour that is systematically devalued because the fact that work is being performed is obscured. Particularly relevant here is the sociospatial mechanism through which labour becomes invisible when it occurs outside spaces culturally recognised as workplaces, thereby diminishing its visibility and social value. This perspective is especially pertinent to live-in care work, which takes place primarily in private households rather than in institutionally recognised workplaces such as hospitals or residential care facilities. As a result, significant dimensions of live-in care labour remain difficult to recognise, regulate, and value as work.

The article further draws on Sheller's (2018) concept of mobility justice to situate these struggles within broader inequalities in the governance of movement. Mobility is not equally distributed but organised through unequal access to infrastructures, resources, and political power. Extending this perspective, bounded transport is understood as simultaneously a condition of employment, a source of labour precarity, and an arena of political mobilisation. Transport is therefore approached not simply as movement between home and work but as a socially produced space where labour relations, care infrastructures, and struggles for justice intersect.

Verlinghieri and Schwanen (2020) further develop mobility justice through a feminist ethics of care, arguing that mobility injustices cannot be understood solely in terms of unequal access or mobility capacity. Instead, they emphasise the social, embodied, and gendered conditions through which mobilities are produced and experienced, calling for approaches to mobility justice that recognise situated knowledge,

diverse experiences, and the participation of affected groups in defining what constitutes just mobility. Their perspective shifts attention from abstract principles of equal movement towards caring forms of justice grounded in recognition, responsibility, and responsiveness to the needs and voices of those whose mobilities are shaped by unequal conditions.

Drawing on cases from Latin and North America, Castañeda et al. (2024) argue that mobility is not only a condition of social reproduction but can also become a terrain of feminist resistance and collective action. Their analysis demonstrates how feminist movements engage with questions of mobility, care, and inequality by challenging the conditions under which movement is enabled, restricted, and valued. This perspective is particularly relevant for transnational live-in care, where unequal infrastructures and social relations shape migrant workers' everyday experiences of mobility, yet can also become a basis for collective claims, solidarity, and demands for recognition.

The Covid-19 pandemic further revealed that both mobility and immobility are fundamental to the organisation of care. Rather than merely disrupting travel, pandemic restrictions exposed how the governance of (im)mobility shapes care provision, labour relations, and workers' wellbeing. Studies have demonstrated that changes in institutional expectations, resource constraints, and public health measures have reconfigured care workers' mobility while intensifying the interdependence between paid and unpaid care responsibilities (Ravensbergen et al., 2024). At the same time, Aulenbacher et al. demonstrated that border closures and travel restrictions produced enforced immobility, profoundly disrupting transnational live-in care arrangements and exposing their dependence on the continuous cross-border circulation of live-in migrant care workers (Aulenbacher et al., 2020).

3. Methodology

3.1. Data Collection

The analysis draws on four complementary sources of qualitative data. First, it analyses European Union, Austrian, and Slovak legislation, policy documents, and official communications concerning labour mobility, live-in care, transport, and occupational safety. These documents were examined to understand the meso level—to identify how transport is regulated, which institutions assume responsibility, and where potential regulatory gaps emerge.

Second, the study draws on online ethnography conducted within three main Slovak social media platforms used by live-in care workers and their organizations, with approximately 20,000 users. These online communities constitute important spaces where caregivers exchange practical information regarding transport, employment opportunities, working conditions, agency practices, and everyday experiences of cross-border mobility. Beyond their practical function, these platforms also serve as spaces of mutual support, collective knowledge production, and political discussion, allowing observation of how mobility-related problems become publicly articulated and collectively interpreted.

These digital spaces are particularly significant because they provide forms of recognition and collective voice for workers whose experiences remain marginalised within formal institutional settings. Through discussions of accidents, transport providers, working conditions, and everyday risks, caregivers transform

individual experiences of vulnerability into shared understandings of the structural conditions shaping transnational care.

Third, the article analyses petitions, open letters, public statements, institutional correspondence, advocacy materials, and campaign documents produced by organisations representing Slovak live-in care workers, particularly the Initiative for Justice in Personal Care in Austria (*Initiative für Gerechtigkeit in der Personenbetreuung in Österreich*—IG24), the Slovak Chamber of Care Workers (*Slovenská komora opatrovateliek*), and the civic initiative "I'm Going Home for Good" (*Idem natrvalo domov* in Slovak). These materials were analysed using qualitative content analysis (Krippendorff, 2018) to reconstruct advocacy claims, identify recurring themes, and examine institutional responses to workers' demands concerning transport safety, labour rights, and mobility governance.

Finally, the analysis is informed by 12 semi-structured interviews conducted with Slovak live-in care workers and representatives of organisations engaged in labour advocacy. These interviews provide insight into everyday experiences of agency-organised transport, perceptions of occupational risk, and workers' interpretations of collective mobilisation. The interviews also reveal how live-in care workers themselves negotiate the contradictions between dependence on mobility infrastructures and efforts to create safer and more autonomous forms of movement.

3.2. Ethical Considerations and Positionality

The author's engagement with the field developed through long-term research on transnational live-in care and sustained interaction with actors involved in the organisation and advocacy of live-in care workers' rights. Through this engagement, contact was established with IG24 and other actors within the Slovak live-in care workers' community, providing insight into how transport risks, accidents, and mobility conditions were experienced, interpreted, and collectively contested by workers themselves.

This proximity to the field required continuous reflexive attention to the researcher's positionality (Sultana, 2007), the relationships through which knowledge was produced, and the ethical responsibilities involved in representing experiences of vulnerability and collective mobilisation. Rather than approaching workers only as subjects exposed to risk, the research recognises them as knowledge producers whose everyday experiences provide critical insight into the organisation and governance of transnational care.

The online ethnographic component of the research draws on approaches to digital ethnography that understand online spaces as embedded within wider social worlds rather than as separate spheres of interaction (Pink et al., 2016). From this perspective, social media platforms used by Slovak live-in care workers are understood as meaningful social spaces where experiences, relationships, and collective interpretations of mobility, work, and vulnerability are produced. The analysis also follows approaches to netnography that recognise online communities as sites of cultural meaning-making and collective practice (Kozinets, 2010).

Although the analysed social media platforms function as important communication spaces for Slovak live-in care workers, they also constitute semi-private environments where participants frequently discuss sensitive issues related to employment, mobility, legal status, and working conditions. User identities are therefore

protected, identifying information has been removed, and quotations have been selected carefully to prevent traceability and minimise potential harm (Franzke et al., 2020). All interviewed participants are anonymised, and pseudonyms are used throughout the article.

Public statements, petitions, and institutional correspondence produced by advocacy organisations such as IG24 and the Slovak Chamber of Care Workers are analysed as public organisational documents and are therefore cited without anonymisation. Where non-public correspondence was used, permission to analyse it was obtained from the respective organisations.

4. Bounded Transport Between Labour Law and Transport Regulation

Although the European Union increasingly recognises long-term care as a major social policy challenge, the mobility infrastructures that sustain cross-border care labour remain largely invisible. The European Care Strategy (European Commission, 2022), for example, promotes accessible and high-quality long-term care but does not explicitly acknowledge the growing dependence of Western European care systems on regularly commuting live-in care workers from Central and Eastern Europe. As a result, the Strategy overlooks the labour mobility arrangements that enable these care systems to function and fails to address the inequalities they generate.

This policy silence extends beyond migration itself to the organisation of mobility. Cross-border movement is generally understood through the principle of free movement guaranteed by Article 45 of the Treaty on the Functioning of the European Union. In contrast, the practical infrastructures enabling that movement remain largely outside policy attention. Regularly organised shuttle vans, coordinated transport networks, and agency-managed travel constitute indispensable elements of the live-in care system. Yet they are rarely recognised as part of employment relations or labour governance.

The absence of mobility infrastructures from European care policy reflects a broader tendency to conceptualise care as occurring within private households while overlooking the infrastructures that make such care possible. Consequently, transport remains framed as a technical or logistical matter rather than as a constitutive component of cross-border labour relations.

Agency-organised bounded transport therefore falls into a regulatory grey zone situated between labour law, transport regulation, and care policy.

European labour law primarily regulates employment relationships, whereas transport legislation focuses on road safety and commercial passenger transport. Neither policy field adequately addresses situations in which mobility itself becomes an integral part of work organisation. Directive 2003/88/EC on working time illustrates this ambiguity. While it regulates maximum working hours and rest periods, it provides no clear guidance regarding whether lengthy journeys undertaken as part of rotational cross-border care should be considered working time. Consequently, questions concerning remuneration, employer responsibility, occupational health protection, accident liability, and insurance remain insufficiently resolved.

Similarly, European road safety initiatives-including the Road Safety Policy Framework and the Vision Zero strategy-primarily address traffic safety rather than the working conditions of highly mobile workers. Fatigue,

prolonged journeys, irregular schedules, and dependence on agency services therefore remain largely absent from occupational safety debates despite posing significant risks to live-in care workers.

This fragmentation produces a particular form of institutional exclusion. Workers are recognised within separate categories as self-employed entrepreneurs, passengers, or service providers-but not as live-in care workers whose mobility constitutes an essential condition of their labour. Because no institutional framework captures this combined position, responsibility for transport safety and working conditions is continuously transferred between different authorities.

These governance gaps continue at the national level. In Slovakia, labour legislation regulates employment relationships but contains almost no provisions addressing the organisation of transport for citizens working abroad. Responsibility for transport safety, labour inspection, road regulation, and contractual arrangements is divided among several institutions, none of which explicitly considers agency-organised transport part of cross-border employment.

Austria, the research case presented in this article, presents a different yet equally fragmented picture. While the country has developed an extensive regulatory framework for 24-hour care, quality assurance mechanisms primarily focus on care recipients and brokerage agencies rather than on the mobility conditions of caregivers themselves. Existing quality standards regulate agency services but do not systematically examine how agencies organise transport or how mobility arrangements affect occupational safety and workers' autonomy.

5. Bounded Transport Between Slovakia and Austria: The Mobility Infrastructure of Live-in Care

5.1. Slovak Live-in Care Workers in Austria: A Transnational Commuting Workforce

According to membership statistics from the Austrian Federal Economic Chamber (Wirtschaftskammer Österreich, 2025), the Austrian self-employed live-in care sector continues to rely heavily on transnational labour mobility. As of 31 December 2024, 11,517 Slovak women were registered as self-employed personal carers (*Personenbetreuerinnen*) in Austria, making Slovak carers the second largest national group after Romanian carers. Although Slovak women have historically constituted one of the key groups sustaining Austria's 24-hour care model, their declining numbers reflect broader transformations in Central and Eastern European care mobility rather than a withdrawal from care work. Instead, many Slovak carers are reconfiguring their mobility trajectories across different care regimes. Some are reaching retirement after two decades of rotational care migration to Austria, while others increasingly provide live-in care within Slovakia, where a growing but largely unregulated market of 24-hour care has emerged. Others redirect their mobility towards countries such as Germany and the Netherlands, where care work is often associated with higher remuneration and more favourable employment conditions.

This live-in care regime depends on the regular cross-border circulation of thousands of workers who travel between Slovakia and Austria in fortnightly rotations. Consequently, transport is not simply a logistical necessity but a constitutive infrastructure of Austrian live-in care. Research by Mairhuber et al. (2024, p. 28), based on a survey of 11,715 live-in care workers (of all nationalities) in Austria, demonstrates that

responsibility for organising this mobility is divided between workers and placement agencies. While most workers arrange transport independently, around 10% rely on agency-organised transport voluntarily, and approximately 23% are required by agencies to use designated transport providers. Although agency-organised transport is generally perceived as safe and convenient, transport costs remain unevenly distributed. Around 11% of workers pay travel expenses entirely themselves, while almost one quarter report that travel allowances fail to cover actual costs.

Earlier research likewise suggests considerable diversity in mobility arrangements. Bahna and Sekulová (2019) estimated that in 2016 approximately 57% of Slovak live-in care workers were employed through placement agencies, while the remainder organised mobility through public transport, private cars or informal transport networks. Access to these alternatives, however, is highly uneven. It depends on workers' place of residence, destination within Austria, access to private vehicles, public transport availability and previous experience with cross-border commuting. Live-in care workers travelling to rural households often face particularly limited transport options.

5.2. Bogus Self-Employment and Bounded Transport

Ninety-two percent of Austria's live-in care workers are self-employed (Amnesty International, 2021). Although they are legally classified as self-employed entrepreneurs, extensive research has shown that this status frequently constitutes bogus self-employment. Rather than operating as genuinely independent service providers, carers remain highly dependent on brokerage agencies that organise recruitment, client allocation, work schedules, fortnightly rotations, and cross-border transport (Aulenbacher et al., 2024; Bauer et al., 2014).

This contradiction between formal autonomy and practical dependence is central to understanding the mobility infrastructure of Austrian live-in care. While self-employment formally implies that workers are free to determine how and when they travel, in practice their mobility is organised through agency-controlled infrastructures that substantially constrain these choices.

Typically, brokerage agencies subcontract transport to small companies operating seven- to nine-seat minibuses under taxi-service licences. Because these vehicles are legally classified as taxi services rather than long-distance passenger transport, they are exempt from several regulatory requirements governing drivers' working hours and mandatory rest periods. As a result, journeys between eastern Slovakia and western Austria frequently last between fifteen and twenty hours and are often undertaken by a single driver. What appears to be a convenient door-to-door service therefore redistributes temporal, physical, and safety risks onto both carers and drivers.

Transport schedules closely follow the fourteen-day rotation system characteristic of Austrian live-in care. Workers frequently leave home during the night or even a day before their shift begins to ensure timely arrival. Although Austrian families typically contribute between EUR 50 and EUR 80 towards travel costs, these reimbursements rarely cover actual expenses, leaving carers to finance the remainder themselves. Furthermore, agencies often cooperate exclusively with particular transport providers, limiting workers' ability to choose alternative forms of travel without potentially affecting future placements. Tight rotation schedules, financial constraints, and limited public transport connections therefore make agency-organised shuttle services the most realistic-and often the only feasible-mobility option for many live-in care workers.

Counselling organisations and live-in care workers themselves consistently identify long journeys, insufficient rest periods, unsafe driving conditions, and dependence on agency-organised transport as major concerns. Some placement agencies have responded by advertising the use of two drivers as a competitive advantage, transforming transport safety into a marketable service rather than recognising it as a basic labour standard. Even informal transport providers operating outside formal agency structures often reproduce similar relations of dependency through regular cross-border routes that remain weakly regulated.

As a result, bounded transport is formally individualised but practically governed through brokerage networks that simultaneously organise recruitment, placement, and transport. As Aulenbacher and Prieler (2024) argue, Austrian regulation has focused primarily on safeguarding the quality of care provision through instruments such as the Austrian Quality Certificate for Brokering Agencies (ÖQZ), while devoting considerably less attention to workers' labour conditions and the mobility infrastructures that sustain transnational care.

6. When a Tragedy Triggers Mobilisation

For many years, the risks associated with agency-organised transport remained an ordinary yet largely invisible dimension of transnational live-in care. Long overnight journeys, exhausted drivers, agency-controlled transport providers and extensive door-to-door routes were widely accepted as part of the infrastructure of rotational care work despite the considerable physical and emotional burden they imposed on live-in care workers and their families. It was only through a series of fatal accidents that bounded transport emerged as an object of public concern and political mobilisation.

This became tragically evident in 2017, when a van crash exposed the hidden human cost of bounded transport, highlighting a labour dimension that is both essential and largely invisible:

> In early October 2017, seven Slovak live-in care workers—Katarína, Ľubica, Lucia, Alena, Jana, Júlia, and Anna—were returning home in an Opel Vivaro minibus after a demanding rotation abroad. What was intended as a rare moment of relief ended abruptly on a first-class road between Nitrica and Nitrianske Sučany, when the minibus driver, for reasons that remain unclear, crossed into the oncoming lane. A speeding truck collided with the vehicle, leaving no opportunity for reaction. The deafening impact and ensuing silence marked a tragedy of enormous proportions. (Boris, 2026)

Beyond its devastating human consequences, the accident exposed the hidden costs of the transnational care economy and made visible a labour dimension that had previously been largely absent from public debate in both Austria and Slovakia.

The accident became a recurring point of reference throughout my interviews. Participants rarely discussed transport without recalling "the accident," suggesting that it has become embedded in the collective memory of Slovak live-in care workers. Rather than remembering only the event itself, interviewees described how it fundamentally changed the way they experienced journeys between Slovakia and Austria. As Milka (Slovak live-in care worker) explained in the interview:

> Some trips take longer than a trip to New York. Loading and unloading passengers is extremely exhausting. And it may not seem like it, but this is also stressful for the family. I remember, after that big accident in 2017, my children, when they were little, were extremely stressed. I would come home early in the morning, and they would be awake; even now, they still keep checking on me on their phones.

Milka's account illustrates that the consequences of bounded transport extend far beyond the journey itself. The risks associated with cross-border mobility reverberate through transnational family life, shaping everyday practices of waiting and monitoring, as well as heightening anxiety. Mobility is thus experienced not only as a logistical necessity but also as an affective dimension of live-in care work whose burdens are shared by workers and their families (Bahna & Sekulová, 2019).

Since 2017, these tragedies have catalysed transnational advocacy, transforming roads themselves into sites of political visibility. Despite precarious employment, fragmented representation, and limited institutional support, Slovak live-in care workers have increasingly drawn upon established political repertoires (Tilly, 2006), including demonstrations, petitions, open letters and public campaigns, to articulate collective claims concerning transport safety, labour rights, and working conditions. Rather than treating repeated accidents as isolated traffic incidents, these initiatives frame them as manifestations of broader structural inequalities embedded in the organisation of transnational live-in care.

One of the first organised responses was the establishment of the civic association Going Home Permanently (*Idem natrvalo domov*), founded by live-in care workers themselves shortly after the 2017 tragedy. In an open letter addressed to then-President Andrej Kiska, the association argued that low wages and deteriorating working conditions in Slovakia compelled women to seek employment abroad while simultaneously exposing them to unsafe transport arrangements. Besides demanding higher wages for caregivers in Slovakia, the association drew attention to contractual clauses requiring workers to use agency-selected transport providers, thereby limiting their autonomy in choosing safer alternatives. It called for stricter regulation of transport agencies, mandatory deployment of a second driver on long-distance routes, systematic monitoring of transport providers, and bilateral dialogue between Austria and caregivers' countries of origin concerning transport regulation within the 24-hour care sector. Following a personal meeting with President Kiska, the association reiterated its demand for a guaranteed minimum monthly salary of EUR 700 for caregivers working in Slovakia. Although the Ministry of Labour, under Minister Ján Richter, rejected this proposal as economically unrealistic, it nevertheless acknowledged the importance of strengthening domestic care infrastructures.

The significance of these demands lay not only in their content but also in how they redefined transport itself. Rather than presenting mobility as a private commuting matter, the association framed transport as an integral component of live-in care work and therefore as a matter of labour rights, occupational safety and state responsibility. By linking transport conditions with migration, wages, and long-term care policy, the association challenged the widespread assumption that the risks of cross-border mobility should be borne by individual workers.

Transnational mobilisation expanded further with the establishment of IG24, founded in Austria in 2021 through cooperation between the Slovak organisation *Iniciatíva24* and the Romanian organisation D.R.E.P.T.

pentru îngrijire. Representing live-in care workers across national boundaries, IG24 combines legal counselling in caregivers' mother tongues with community support, rights-based advocacy, and campaigns challenging exploitative employment arrangements, including bogus self-employment. Through initiatives such as "Our Work, Our Rights!" and Care4Care, the organisation has developed multilingual resources, workshops, and transnational collaborations designed to improve working conditions while making visible the often-hidden realities of Austria's live-in care system.

In recent years, transport safety has become one of IG24's principal areas of advocacy. Following another fatal van accident on 1 September 2022, the organisation held a public demonstration in front of the Austrian Ministry of Social Affairs in Vienna. Rather than framing the accident as an isolated event, protesters explicitly criticised the transformation of transport into a profit-oriented business model in which live-in care workers are contractually tied to agency-selected transport providers and commercial efficiency takes precedence over workers' safety. In doing so, IG24 shifted public attention from individual tragedies towards the structural organisation of bounded transport, arguing that transport risks are inseparable from the broader political economy of transnational care.

Following another fatal accident on 21 December 2023, in which a van carrying six Slovak live-in care workers collided with a truck, killing one caregiver, seriously injuring another, and traumatising the remaining passengers, IG24 intensified its advocacy efforts. Rather than treating the accident as an isolated event, the organisation submitted a formal request to then-President Zuzana Čaputová, calling for an expert assessment of tied transport arrangements and agency interference with caregivers' autonomy in choosing transport providers. In its response, the President's Office acknowledged both the gravity and recurring nature of these tragedies, stating:

> We are deeply saddened by the recent events, which constitute yet another very tragic indication of the critical situation faced by Slovak care workers. Please be assured that this matter will receive attention in the near future.

The subsequent institutional response, however, revealed the fragmented governance of bounded transport. In February 2024, the Ministry of Transport forwarded IG24's request to the Slovak National Labour Inspectorate. While acknowledging the seriousness of repeated transport accidents, the Inspectorate argued that it lacked the authority to assess contractual clauses regulating agency-selected transport and referred the matter to the Ministry of Justice of the Slovak Republic. Responsibility for road safety was simultaneously delegated to the Police, while labour inspections remained confined to illegal employment and drivers' working hours. The Ministry of Transport similarly maintained that it could not intervene in workers' choice of licensed transport providers, redirecting questions concerning working conditions to the Ministry of Labour, Social Affairs, and Family. Rather than producing regulatory change, responsibility circulated between institutions, with no public authority recognising bounded transport as an integral component of transnational care work or assuming responsibility for its regulation. The repeated transfer of competence illustrates how transport remains institutionally disconnected from care governance despite being indispensable to its everyday functioning.

Concerns about transport were also articulated by other organisations representing care workers. The Slovak Chamber of Care Workers (*Slovenská komora opatrovateliek*), representing caregivers employed both in

Slovakia and abroad, has repeatedly issued petitions, open letters, and public statements drawing attention to exploitative working conditions across the care sector. In its press release of 25 July 2024, "Yesterday Was Late! We Are Plunging into an Abyss in the Care of Our Own Citizens" (in Slovak: *Včera bolo neskoro! Rútime sa do priepasti v starostlivosti o našich vlastných občanov*), the Chamber explicitly linked the repeated transport tragedies experienced by live-in care workers to the chronic underfunding of long-term care in Slovakia. Rather than treating fatal accidents as unfortunate incidents, the Chamber argued that poor wages, deteriorating working conditions, and the absence of meaningful public investment continue to compel thousands of Slovak caregivers to seek employment abroad. In this way, the tragedies beginning with the 2017 crash became symbols of wider structural deficiencies in Slovak care policy, linking cross-border labour mobility to broader questions of social justice, gender inequality, and the social valuation of care work.

6.1. Digital Acts of Remembrance: Creating Spaces of Belonging and Recognition Among Slovak Live-in Care Workers

Collective responses to bounded transport do not occur solely through formal organisations or institutional advocacy. My research shows that digital platforms used by Slovak live-in care workers have become important spaces for creating belonging and recognition among migrant care workers. Through acts of digital remembrance (Fusco et al., 2024), sharing, and collective reflection, these online communities transform experiences of mobility, risk, and loss into shared narratives about the realities of transnational care work. Social media posts following transport accidents do not merely document individual tragedies; they create spaces where workers connect personal experiences with the broader challenges of living and working across borders. By circulating memories of previous accidents, discussing transport routes, and sharing experiences with different agencies, caregivers collectively build knowledge about the vulnerabilities associated with their mobility.

One Slovak live-in care worker, for example, shared her experience after surviving a serious traffic accident while returning home from Austria:

> I want to share my story. I worked, and I still have, a trade license as a caregiver in Austria. A year ago, I had a serious car accident on my way home from work. It happened near Vienna. I would not wish it on anyone. I suffered a broken cervical spine, a broken jaw, a severe concussion, and unbelievable bruises and pain. I do not remember anything from the accident. I was operated on in Vienna at AKH, and I would like to thank the entire staff, especially Dr XX. Thank God I recovered and was able to return home to my children. (Post on a social media platform for Slovak live-in care workers)

The discussions generated by such testimonies demonstrate how digital spaces function as infrastructures of collective interpretation. Rather than understanding accidents as isolated personal experiences, caregivers place them within shared discussions about long journeys, agency-organised transport, and the everyday uncertainties of cross-border care work. Through these exchanges, workers articulate what Zuzana Uhde conceptualises as *lived critique*: reflections emerging from everyday experiences through which people make sense of the conditions shaping their lives (Uhde, 2019).

Live-in care workers' online discussions also reveal reflections on the personal consequences of transnational mobility. Many question why providing care requires them to spend extended periods away

from their own homes, families, and communities. These reflections express the tensions inherent in their mobility: travelling abroad provides important opportunities and livelihoods, while simultaneously involving separation, exhaustion, and exposure to risks that are often taken for granted.

Digital platforms also provide spaces of collective remembrance. Following the deaths of colleagues, live-in care workers share memorial messages acknowledging those who have disappeared from the transnational care community. One such post following a tragedy in January 2021 stated: "Please pray for all the dear caregivers who left us so unexpectedly." These practices of mourning create forms of recognition for workers whose lives and experiences often remain unnoticed beyond their immediate communities. Remembering deceased colleagues is therefore not only an expression of grief; it is also a way of affirming shared belonging and acknowledging the value of lives connected through transnational care work.

The significance of these digital practices extends beyond national boundaries. Following a fatal accident on the Austrian A2 motorway in April 2025 involving Ukrainian caregivers travelling from Milan to Ukraine, the live-in care workers' organisation IG24 responded:

> Terrible accident on the A2—five caregivers lost their lives! On April 12, 2025, five Ukrainian colleagues lost their lives in a serious traffic accident; two others were severely injured. The driver, a Ukrainian man with 25 years of experience, is believed to have been overtired. The public prosecutor's office has filed charges for negligent homicide. Accidents like this reflect structural inequalities!

Responses to such events demonstrate that bounded transport has become a shared experience that connects migrant care workers across national backgrounds. Slovak, Romanian, Ukrainian, and other caregivers recognise common experiences of mobility, uncertainty, and vulnerability. Digital acts of remembrance, therefore, become practices of "inclusion from below" (Scuzzarello & Moroșanu, 2023): By remembering colleagues, exchanging experiences, and creating spaces of mutual recognition, migrant live-in care workers build communities of belonging that extend beyond national borders.

7. Everyday Practices of Bounded Transport: Making Journeys Safer

While collective mobilisation has transformed bounded transport into a visible political issue, interviews with Slovak live-in care workers suggest that institutional advocacy has done little to alter the everyday realities of cross-border mobility. Rather than replacing workers' own efforts to manage transport risks, collective action coexists with everyday practices through which live-in care workers negotiate the constraints of agency-organised transport. The interviews reveal how workers adapt their mobility decisions and travel routines to navigate the persistent risks associated with rotational cross-border care.

One important strategy concerns the selection of workplaces themselves. Rather than choosing employment solely based on wages or working conditions, interviewees increasingly considered transport accessibility when deciding where to work. As Eva (Slovak live-in care worker) explained:

> I was also stressed out about those journeys, especially after my friend's accident, so now I only go to Vienna. There is a bus from Košice to Vienna. In Vienna, you need good German and experience. They are more selective. And that suits me fine.

For Eva, transport safety became an important factor shaping labour mobility, demonstrating how memories of fatal accidents continue to influence workers' employment decisions long after the events themselves. Choosing destinations with direct transport connections thus becomes a way of reducing exposure to the uncertainties of agency-organised mobility.

Despite such strategies, most interviewees remained dependent on agency-organised door-to-door transport, which they consistently described as physically exhausting and potentially dangerous. Iveta (Slovak live-in care worker) recalled:

> Those journeys, before they pick you up in villages and you finally get home to the East, can easily take 20 hours. The picking up never ends; the driver keeps watching his mobile phone and coordinating things. It is convenient because they pick you up right in front of your house, but on the other hand, it is extremely long and dangerous.

These accounts suggest that bounded transport is experienced as an extension of live-in care work itself rather than merely a means of reaching the workplace. Long journeys, repeated passenger collection, and overnight driving become integral components of rotational care, extending the temporal and physical demands of live-in care work.

Interviewees also reflected on collectively shared practices aimed at reducing transport risks. Rather than relying on formal safety measures, they assumed responsibility for supporting drivers during long overnight journeys. As Katarína (Slovak live-in care worker) explained:

> Red Bull, coffee, talking, and fresh air. This helps. We take turns with the driver; one of us always talks to him while the others can rest. Then we stop, although some complain that we need too many breaks, but we have an excuse; we're women of a certain age.

These informal routines illustrate how responsibility for transport safety is effectively redistributed to live-in care workers themselves. In the absence of institutional guarantees, live-in care workers develop individual and shared forms of practical knowledge that help sustain the mobility infrastructures on which transnational care depends. Their everyday strategies do not eliminate the risks of bounded transport but instead reveal how live-in care workers continuously compensate for the structural shortcomings of the cross-border care regime.

8. Conclusion

This article began with a simple empirical observation. Every two to four weeks, thousands of Slovak migrant live-in care workers travel between their homes and Austrian households in agency-organised minibuses. These journeys are usually treated as a practical necessity lying outside the care relationship itself. By following bounded transport, however, this article has shown that mobility is not peripheral to transnational live-in care but constitutive of it.

Viewing transport through the perspective of Slovak live-in care workers in Austria makes visible a dimension of European care regimes that largely escapes existing governance. Although cross-border mobility is indispensable to the reproduction of transnational care, responsibility for its organisation remains

fragmented across labour law, transport regulation, and care policy. As long as mobility is treated as a private commuting matter rather than as an integral component of care work, the risks associated with transport remain individualised.

The article contributes to broader feminist debates on the political economy of care, mobility justice, and social reproduction. Following Abraham and Aulenbacher's (2019) arguments on the tensions generated by the marketisation of care, this article draws attention to the democratic countermovements that emerge when care arrangements organised through market logics produce experiences of insecurity, inequality, and exclusion. The mobilisation of migrant live-in care workers around transport accidents illustrates such a countermovement from below. By challenging unsafe transport conditions, demanding recognition, and making visible the hidden costs of transnational care mobility, live-in care workers do not simply resist particular forms of exploitation but also articulate broader claims about how care and mobility should be organised.

Building on Castañeda et al.'s (2024) argument that mobility is constitutive of social reproduction, this article further demonstrates how bounded transport reveals the unequal conditions that sustain transnational care. The empirical analysis demonstrates that bounded transport is not only an infrastructure through which inequalities are reproduced but also an infrastructure of collective mobilisation and recognition. Fatal accidents transformed what had long been accepted as an ordinary yet largely invisible part of transnational care work into an object of public contestation. Live-in care workers' organisations, grassroots initiatives, and advocacy groups reframed transport from an individual responsibility into a collective issue concerning labour rights, mobility justice, and care governance. Through petitions, public campaigns, media interventions, and demands for safer transport conditions, they challenged the normalisation of dangerous mobility and exposed the fragmented responsibilities surrounding cross-border care arrangements. These forms of mobilisation demonstrate that Slovak live-in care workers are not only affected by mobility regimes but also actively shape debates about their regulation and transformation.

Collective mobilisation also extends beyond formal organisations. Digital platforms used by migrant live-in care workers have become important spaces where experiences of mobility, risk, and loss are collectively interpreted and remembered. Through digital acts of remembrance, lived critique, and everyday exchanges of experience, workers transform individual encounters with vulnerability into shared understandings of the conditions that shape transnational care. They demonstrate how experiences of exclusion can become the basis for collective voice, solidarity, and claims for recognition.

Thinking with bounded transport thus contributes to feminist scholarship by connecting debates on the political economy of care, mobility justice, and social reproduction. Recognising mobility as part of live-in care work is therefore not only essential for improving labour regulation, transport governance, and care policy, but also for developing more socially inclusive approaches that acknowledge migrant live-in care workers—both within and beyond the EU—not merely as a flexible labour force but as workers, carers and political actors whose mobility underpins Europe's ageing societies.

Acknowledgments

This article is dedicated to all the live-in care workers who regularly travel across Europe, literally risking their lives to reach the people for whom they provide care. I am deeply grateful to IG24 for their openness to this

research and for their generous support and assistance throughout the fieldwork. I gratefully acknowledge my colleague, Maroš Matiaško, for his valuable legal consultations and support during the preparation of this manuscript. I also thank the anonymous reviewers for their constructive feedback and the editors for their careful editorial work.

Funding

This article was supported by the Volkswagen Foundation through the Challenges and Potentials for Europe programme (CareOrg project).

Conflict of Interests

The author declares no conflict of interest.

Data Availability

Due to the nature of the research and project ethical approval, data sharing does not apply to this article.

LLMs Disclosure

As a non-native English speaker, the author used ChatGPT-4o and Grammarly for language checking and editorial refinement. The author reviewed and approved all final content, all analytical interpretations, and argumentation.

References

Abraham, M., & Aulenbacher, B. (2019). Contested capitalism: Some reflections on countermovements, social justice and the task for sociology. In K. Dörre, H. Rosa, K. Becker, S. Bose, & B. Seyd (Eds.), *Große Transformation? Zur Zukunft moderner Gesellschaften* (pp. 527–547). Springer.

Amnesty International. (2021, July 15). *Austria: Women migrant care workers demand rights*.

Aulenbacher, B., Ezzeddine, P., Gábriel, D., Leiblfinger, M., Milankovics, K., & Prieler, V. (2020). Facing Covid-19: Live-in care in Central Europe. *Global Dialogue*, *10*(3), 23–24.

Aulenbacher, B., & Leiblfinger, M. (2019). The "fictitious commodity" care and the reciprocity of caring: A Polanyian and neo-institutionalist perspective on the brokering of 24-hour care. In R. Atzmüller, B. Aulenbacher, U. Brand, F. Décieux, K. Fischer, & B. Sauer (Eds.), *Capitalism in transformation: Movements and countermovements in the 21st century* (pp. 245–260). Edward Elgar.

Aulenbacher, B., & Prieler, V. (2024). The 'good agency'? On the interplay of formalization and informality in the contested marketization of live-in care in Austria. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 79–94). Sage.

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage Publications.

Bahna, M., & Sekulová, M. (2019). *Cross-border care: Lessons from Central Europe*. Palgrave Macmillan.

Bauer, G., Haidinger, B., & Österle, A. (2014). Three domains of migrant domestic care work: The interplay of care, employment and migration policies in Austria. In B. Anderson & I. Shutes (Eds.), *Migration and care labour* (pp. 67–86). Palgrave Macmillan.

Boris, Z. (2026, January 31). *Prípad smrti siedmich opatrovateliek*. *Viedencan*. https://viedencan.at/pripad-smrti-siedmich-opatrovateliek

Buier, N. (2023). The anthropology of infrastructure: The boom and the bubble? *Focaal*, *95*, 46–60. https://doi.org/10.3167/fcl.2022.012401

Castañeda, P., Solís, A., & Sheller, M. (2024). Feminism and mobility justice: Examining relations of care and mobilities across scales. In V. Preston, S. McLafferty, M. Maciejewska, & B. Yeoh (Eds.), *Handbook of gender and mobilities* (pp. 58–74). Edward Elgar Publishing.

European Commission. (2022). *European care strategy: For carers and care receivers*. Publications Office of the European Union.

Ezzeddine, P., & Matiaško, M. (2026). Live-in care on trial: The failed promise of solidarity in European care governance. *Economy and Society*, *55*(2), 347–365. https://doi.org/10.1080/03085147.2026.2631338

Ezzeddine, P., & Uhde, Z. (2025). Borderscapes of care in Europe: The case of Czech live-in care workers in Germany. In B. Zucca Micheletto & N. Roman (Eds.), *Women, migration and the exchange of knowledge from the sixteenth to the twenty-first century* (pp. 399–418). Palgrave Macmillan.

Franzke, A. S., Bechmann, A., Zimmer, M., & Ess, C. M. (Eds.). (2020). *Internet research: Ethical guidelines 3.0*. Association of Internet Researchers. https://aoir.org/reports/ethics3.pdf

Fusco, R., Ciliberti, R., Licata, M., & Picozzi, M. (2024). Ritual and mourning in the digital era: Between virtual technology and ethical controversies. *Acta Biomedica*, *95*(3), Article 2024120.

Hatton, E. (2017). Mechanisms of invisibility: Rethinking the concept of invisible work. *Work, Employment and Society*, *31*(2), 336–351.

Katona, N., & Melegh, A. (Eds.). (2020). *Towards a scarcity of care: Tensions and contradictions in transnational elderly care in Central and Eastern Europe*. Friedrich-Ebert-Stiftung.

Kozinets, R. V. (2010). *Netnography: Doing ethnographic research online*. Sage Publications.

Krippendorff, K. (2018). *Content analysis: An introduction to its methodology* (4th ed.). Sage Publications.

Mairhuber, I., Schadauer, A., Neuhauser, J., & Matei, F. (2024). *Das Unsichtbare sichtbar machen: Datenerhebung zu Personenbetreuer_innen in österreichischen Privathaushalten*. FORBA.

Matiaško, M. (2026). The right to care and support: From care theory to human rights law. *Social Inclusion*, *14*, 12056. https://doi.org/10.17645/si.12056

Larkin, B. (2013). The politics and poetics of infrastructure. *Annual Review of Anthropology*, *42*, 327–343. https://doi.org/10.1146/annurev-anthro-092412-155522

Pink, S., Horst, H. A., Postill, J., Hjorth, L., Lewis, T., & Tacchi, J. (2016). *Digital ethnography: Principles and practice*. Sage Publications.

Polanyi, K. (2001). *The great transformation: The political and economic origins of our time*. Beacon Press. (Original work published 1944)

Ravensbergen, L., Mehta, S., Sethi, B., Ward-Griffin, C., & Williams, A. (2024). Double-duty carers' health and wellbeing during COVID-19: Exploring the role of mobility of the care economy in Southern Ontario, Canada. *International Journal of Environmental Research and Public Health*, *21*(6), Article 730.

Scuzzarello, S., & Moroșanu, L. (2023). Integration and intersectionality: Boundaries and belonging "from above" and "from below." Introduction to the special issue. *Ethnic and Racial Studies*, *46*(14), 2991–3013.

Sheller, M. (2018). *Mobility justice: The politics of movement in an age of extremes*. Verso.

Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *ACME: An International Journal for Critical Geographies*, *6*(3), 374–385.

Tilly, C. (2006). *Regimes and repertoires*. University of Chicago Press.

Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.

Tronto, J. C. (2013). *Caring democracy: Markets, equality, and justice*. New York University Press.

Uhde, Z. (2019). Claims for global justice: Migration as lived critique of injustice. In J. C. Velasco & M. C. La Barbera (Eds.), *Challenging the borders of justice in the age of migrations* (pp. 183–204). Springer.

Verlinghieri, E., & Schwanen, T. (2020). Transport and mobility justice: Evolving discussions. *Journal of Transport Geography*, *87*, Article 102798. https://doi.org/10.1016/j.jtrangeo.2020.102798

Wirtschaftskammer Österreich. (2025). *Mitgliederstatistik 2024*. https://www.wko.at/oe/statistik/mitgliederstatistik/mitgliederstatistik24.pdf

Xiang, B., & Lindquist, J. (2014). Migration infrastructure. *International Migration Review*, *48*(Suppl. 1), S122–S148.

About the Authors



Petra Ezzeddine is an assistant professor at the Department of Social and Cultural Anthropology, Charles University, Prague. Her research interests include migration, gender studies, and the anthropology of care. Her work particularly focuses on domestic and cross-border care in Central and Eastern Europe, informal and live-in care practices, and the social dynamics of care work. She is also engaged in applied anthropology, exploring how anthropological knowledge can inform social policy, labour regulations, and community-based initiatives.

Social Inclusion
2026 • Volume 14 • Article 12295
https://doi.org/10.17645/si.12295

cogitatio

REVIEW

Open Access Journal

In Times of the Market and Community Shift: On Live-In Care and Caring Communities

Brigitte Aulenbacher [1], Klaus Wegleitner [2,3], Jonas Hagedorn [4], and Bernhard Emunds [5]

[1] Institute of Sociology, Johannes Kepler University Linz, Austria
[2] Center for Interdisciplinary Research on Aging and Care (CIRAC), University of Graz, Austria
[3] Institute of Pastoral Theology, University of Graz, Austria
[4] Theological Faculty Paderborn, Germany
[5] Nell-Breuning Institute, Sankt Georgen Graduate School of Philosophy and Theology, Germany

Correspondence: Brigitte Aulenbacher (brigitte.aulenbacher@jku.at)

Submitted: 28 February 2026 **Accepted:** 4 May 2026 **Published:** 25 June 2026

Issue: This review is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Under the auspices of neoliberalism, senior care provision is facing both a market and community shift. The respective shifts in societal care responsibilities are particularly evident in how care provision and arrangements are influenced by the state, market, family, and community. This article is conceptualised as a literature review, reflecting on and reinterpreting research results. It spotlights significant tendencies in the field of care and care work, such as their enforced transnational and local commodification and communitisation in neoliberalism, and how they affect demands and claims on care, work, and housing. It continues by reflecting on research on live-in care and caring communities in Austria and Germany as paradigmatic cases of the market and community shift; it shows how these modes of care provision and care arrangements create a specific life-care-work-housing nexus and are challenged by, contradictory to, or conflicting with the demands and claims on decent or good care, work, and housing. Finally, the article concludes with some comparative remarks on both modes of care provision.

Keywords

care responsibility; care work; caring communities; community-based care provision; demands and claims on care; housing; hybrid and unequal care arrangements; live-in care; market-based care provision

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

This article reflects on demands and claims in senior care with regard to care, care work, and housing. Care "can be primarily seen as the work of looking after the physical, psychological, emotional and developmental needs of one or more people," be it by paid or unpaid labour and including the work done to care for oneself (Kofman & Raghuram, 2015, p. 52). As a social practice, care "embraces the range of human experiences and relationships of obligation, trust, loyalty and commitment concerned with the well-being of others" and oneself (p. 52). In this narrower and wider sense, care and care work consist of all the relations, practices, and activities in terms of self-care and care for others, answering to the contingency of life in the life course as well as in everyday life (Klinger, 2013, pp. 81–83) and on the individual, institutional, and societal level (Tronto, 2013, pp. 17–64). Housing can be considered as one of the loci where care provision, in terms of care as well as care work, takes place. In case of the private household or collective forms of housing (Roller & Schneider, 2024, pp. 12–14), the two also figure as living spaces and workplaces (Lutz & Benazha, 2024; Palenga-Möllenbeck & Fiebig-Spindler, 2025; Roller et al., 2024). In this context, housing provision, its quality, affordability, and accessibility, can be considered as infrastructure of care and care work preconditioning, affecting, co-shaping, or limiting their provisioning (Tronto, 2025, p. 695).

This article is organised as a literature review and joint discussion on research on neoliberal developments and tendencies in the field of care and care work, and on two modes of senior care provision: live-in care and caring communities as paradigmatic cases of the market and community shift. The article aims to reflect on the neoliberal shift of societal care responsibilities and the respective demands and claims it is imposing on the two modes of senior care provision mentioned above, both in terms of care and housing arrangements. Section 2 of the article discusses tendencies in contemporary capitalism that are setting care and housing provision under pressure, as well as the transnational and local organisation of care and care work. It introduces the life–care–work–housing nexus together with the demands and claims emerging from or related to it. They figure as tertia comparationis, allowing us to compare the modes of care provision and care arrangements in line with and bridging the respective research strands focusing on either live-in care or caring communities. In the face of shifting care responsibilities from family and state to market, or from family and state to community, Section 3 reflects on live-in care and caring communities—referring to the state-of-the-art research in Austria and Germany. In Section 4, the article concludes with some remarks on the two modes of care and housing provision and respective care arrangements.

2. Approaching the Neoliberal Market and Community Shift, Transnational and Local Care Provision, and Demands and Claims on Care

Current global geopolitical upheavals and disruptions are characterised by market dictates and a logic of "deals," authoritarian political developments, the principle of "might makes right," and a renewed global militarisation. Issues such as peaceful coexistence, caring for one another, dealing with the vulnerability and dependency of life, and social security are evidently important topics but more present in the niches of the public discourses on care and housing than in the mainstream or subject to protest—be it by trade unions or social movements (Knobloch et al., 2022; Meier-Gräwe et al., 2023; Rudolph & Schmitt, 2019). On the one hand, this mirrors decades in which unrestrained capitalism has led to the increasing commodification of all areas of life, including care. The neoliberal restructuring of the welfare state since the 1980s diminishes opportunities to reconfigure care and housing provision in relation to more political and ethical than

economic aspects. This development led to crises of care and housing provision in many parts of the world—including the wealthier world regions losing their longstanding ideals or dreams of prosperity, wealth, and security (Aulenbacher, Novy, et al., 2025; Dowling, 2021; Katona & Melegh, 2020). Furthermore, social policies of the last decade are more and more influenced by authoritarian political tendencies combined with new forms of national protectionism and social polarisation (Atzmüller et al., 2023). On the other hand, the rediscovery of the community, be it by volunteer work or civil society engagement, and the respective initiatives and projects, be it as part of progressive or regressive social movements, can be understood as a reaction to experienced effects of neoliberalism and market fundamentalism (Aulenbacher et al., 2018; Karner & Weicht, 2016). Moreover, they can also be considered an element of neoliberal governance drawing on voluntariness to shift societal responsibility into the community sphere, thereby complementing or replacing public services of the welfare state (Kessl & Schoneville, 2024; van Dyk et al., 2026; van Dyk & Haubner, 2021). In terms of societal responsibility, the market and the community shift therefore have to be considered as conflicting as well as complementary tendencies, which are historically related to each other by the neoliberal mode of care provision and its (destructive) effects.

2.1. Set Under Pressure and Challenged: Care, Care Work, and Housing in Later Life

Questions about the conditions for a sustainable and caring society often appear naïve or cynical in light of "careless capitalism" (Lynch, 2021), as well as the precarity of care and poor working conditions in the crises-driven sector of senior care provision. While care and care work are feminised and ethnicised, undervalued, privatised, and externalised (Klinger, 2013), the market shift in neoliberalism takes, more and more, centre stage (Farris & Marchetti, 2017). This transfers risks onto private households, especially women and migrant workers, or it tends to replace professional work with lay work, provided by unpaid or volunteer workers (van Dyk & Haubner, 2021). In addition, community-based modes of care provision are affected by neoliberalism through its impact on public funding (van Dyk, 2025) and by austerity-driven social policies in particular, making it a challenge to develop new care arrangements.

The described developments make care and care work—which are in line with an ethics of care that recognises the ever-given contingency, vulnerability, and neediness of life—more and more impossible (Tronto, 2013, p. 18–45). In later life, the vulnerability and neediness of existence become especially acute (Grenier et al., 2020). Marketised care provision, be it by non- or for-profit organisations, is accessible to those who are able to pay for it. Social exclusion in later life marks these overlaps along lines of class, gender, citizenship, ethnicity, neighbourhood, and belonging (Walsh et al., 2021). In postmigrant societies, recognition and democratic participation shape access to and responsiveness within care, housing, and labour (Foroutan, 2021; Huxel et al., 2021; Römhild, 2017). In this context, live-in care and caring communities have in common that they create a specific life–care–work–housing nexus which is characterised by blurring boundaries between living space and workplace, and influenced by the market or community shift inherent to these care arrangements.

2.2. Highlighting the Transnational and Local Dimensions of Senior Care Provision

In the case of the market shift and under the auspices of the austerity-driven reorganisation of the welfare state, on the one hand, care provision is becoming increasingly precarious, while society and individuals become ever more dependent on care work in light of demographic change. On the other hand, new care

industries emerge and shape new forms of "commodification," "marketization," and "corporatization" (Farris & Marchetti, 2017) of care, care work, and care provision that are strongly interrelated with the trans- and internationalisation of labour and politics and create new patterns of migration. From the perspective of the receiving countries, labour and care migration can be understood as a coping strategy. It promises to make care and care work locally available and home care feasible while the respective trans- and international recruitment of the migrant workforce reorganises inequalities between regions as well as between care recipients and workers (Anderson & Shutes, 2014; Huxel et al., 2021; Kofman & Raghuram, 2015; Lutz, 2018b; Melegh, 2023; Yeates, 2009). Following Lutz's (2018a, pp. 578–584) concept of care migration, these transnational care arrangements can be understood not only as part of global care chains but also as embedded in broader forms of care circulation, in which transnational social inequality and the marketisation of care provision become structuring forces in the organisation and distribution of care and labour. This is evident in the creation of new market-based modes of care provision (Aulenbacher et al., 2024; Chee, 2025) and subsequent care gaps between receiving and sending countries.

In this context, not only labour but also emotional and social resources (e.g., skills, capacities) are transferred across borders. In the sending countries, this "increases the care deficit through the absence of formal and informal carers and it strips the health and care systems in those countries of their vital resources" (Williams, 2011, p. 28). In the receiving countries' transnational modes of care provision and care arrangements, seniors (often in socio-economically privileged positions) and migrant care workers (in structurally disadvantaged positions) enter into an asymmetrical relationship of economic dependency, in terms of citizenship and corresponding rights and the informal and formal negotiation of working and living conditions on the individual as well as the institutional level (Lutz, 2018b; Palenga-Möllenbeck, 2022; Palenga-Möllenbeck & Fiebig-Spindler, 2025). This lens clarifies how transnational care provision is co-constructed by marketisation, precarious labour, and metricised welfare in postmigrant societies (Huxel et al., 2021).

In the case of the community shift, we can observe, across different national contexts, the emergence of community-based modes of care provision. On the one hand, these initiatives arise as reactions to care gaps, welfare retrenchment, and the marketisation and corporatisation of care. On the other hand, they also speak to broader transformations of late-modern societies—characterised by increasing precarity, fluidity, and instability of social ties. In this context, questions of belonging, rootedness, and meaningful social bonds gain particular importance. Community-based care initiatives address these issues by seeking to re-embed care in local social relations and in the everyday life contexts of seniors. Caring communities (Sempach et al., 2023) and caring neighbourhood (De Donder et al., 2024) initiatives or civic care cooperatives are locally embedded and often organised around the life–care–work–housing nexus, aiming at connecting living arrangements, care practices, and work relations in new ways.

From the perspective of social capital theories (Bourdieu, 1986; Claridge, 2018; Putnam, 1994), these developments can be understood as attempts to mobilise and rebuild local capacities in the form of trust, reciprocity, and dense associational networks. At the same time, these efforts to build trust and belonging are embedded in a context in which access to social capital is unequally distributed. Through support network theories, these community-based initiatives can be understood as a reconfiguration of support relations. Care and everyday support are embedded in informal networks of households, neighbours, and kin (Pahl, 1984), within which unequal power relations, gendered expectations, and the uneven distribution of

responsibilities within and between households tend to remain socially invisible—that is, they are normalised as "natural" or "appropriate" rather than problematised as relations of inequality. From this perspective, we can understand community-based care as the (re)organisation of locally grounded yet partly transnational networks of support, in which formal and informal, familial and non-familial, paid and unpaid actors interact and in which migrant care workers occupy specific, often precarious positions.

Taken together, market and community shifts do not simply close existing care gaps, but reassemble and redistribute them in often problematic ways, through commodified, transnational live-in care on the one hand, and locally embedded, civically-driven caring communities on the other. Both types of arrangements mobilise and reshape support networks under unequal conditions of resources, recognitions, and rights, frequently relying on unpaid or underpaid work and risking the reproduction—or even deepening—of societal inequalities.

2.3. Hybrid and Unequal Care Arrangements and Demands and Claims in Senior Care Provision

The market and the community shift mark overarching tendencies regarding the anticipated or aimed-at societal responsibility for care provision. This is particularly evident in the hybrid and unequal modes and forms of care provision in the field of senior care. Modes of care provision and the respective care arrangements are embedded in the social fabric of the society and take shape through its normative and institutional order and the relations of inequality inherent to it, among them the relations of gender, race, and class. In the case of Austria and Germany, care provision and the related forms of housing provision are typically embedded in the welfare state, and care work is organised by the private and third sector, state, private household/the family, and social networks/communities. This institutional and normative setting, e.g., concerning public funding and social policies, expectations of different parties involved or of historically given responsibilities, as well as the care arrangements are influenced by the interplay of interfering or conflicting "institutional logics" (Thornton et al., 2012): those of the state, market, corporation, family, and community and—where the church or professions are involved—the respective religious and professional orientations (Aulenbacher et al., 2018; Dammayr, 2019). In the market-, as well as community-based care arrangements, these "logics" serve as sensemaking orientations, be it as beliefs, norms, or values, guiding individual, collective, and organisational practices, giving identity and authority to actors and legitimising their activities (Thornton et al., 2012, pp. 2, 73). In terms of inequality, care arrangements are also embedded in the normative and institutional societal order and thereby stratified by gender, ethnicity/race, and class with regard to the historically-given division of labour, paid as well as unpaid labour, and the accessibility and affordability of care and housing (Aulenbacher et al., 2018). Both the hybrid and unequal shape of care provision and arrangements have to be taken into consideration regarding the demands and claims on care and care work, as well as housing.

In the sociology of work, Hürtgen and Voswinkel's (2014, p. 42) study stimulated research on claims on work by distinguishing them from wishes. Unlike wishes, which can be considered to be more or less arbitrary, claims are rooted in and justified and legitimised by the values of modern society, thereby becoming considered to represent "normality" (Hürtgen & Voswinkel, 2014). Building on this and drawing on the perspective of "institutional logics" and French pragmatism, Dammayr (2019, pp. 20–31) distinguishes demands and claims to investigate care and care work in the field of senior care provision. Claims are expectations, for instance, the claim on autonomy, justice, and equality (Dubet, 2008) that people refer to in a justified manner. Their relatedness to "universal, shared normative beliefs and norms" (Dammayr, 2019,

p. 28) constitutes and legitimises the raising of claims. In the case of care and care work, claims can be considered as "sensemaking" expectations with regard to their quality, be it self-care or care for others (Dammayr, 2019, pp. 31–47). Demands refer to the social fabric of the society and perform as functional requirements, influenced by the "institutional logics" of the market, corporation, state, profession, family, community, religion, as well as the given division of labour (Aulenbacher et al., 2018; Dammayr, 2019). For instance, in the face of the neoliberal reorganisation of care responsibilities, demands referring to the market shift, and claims related to the professional ethics of care and the respective expectations on decent or even good care, work, and housing are contradictory and conflicting (Dammayr, 2019, pp. 394–414). However, demands and claims can contradict and conflict with each other not only in combination, but also separately.

Through the lenses of demands and claims, we can take into account how modes of care provision and the respective care arrangements are embedded in the normative and institutional order of the society and its inherent relations of inequality. Thereby, demands and claims are suitable to figure as a tertium comparationis for our joint discussion of research on live-in care and caring communities and to reflect on the respective concepts and expectations of decent or even good care. In analysing the demands and claims for live-in care and caring communities, the article focuses on the creation of the respective life–care–work–housing nexus. This is what live-in care and caring communities have in common, but in different ways. Therefore, this nexus is suitable to figure as a tertium comparationis, allowing us to compare these care arrangements.

3. Through the Lenses of Demands and Claims: Reflecting on Research on Live-In Care and Caring Communities in Austria and Germany

The cases of live-in care and caring communities represent two established and (concerning live-in care) widely and (concerning caring communities) increasingly used care arrangements. They consist of different combinations of life, care, work, and housing, and thus also of interrelations between the respective spaces of living and workplaces. They are affected by the market or community shift in the societal reorganisation of care responsibilities, the transnationalisation of labour, care, and politics, and the local organisation of care provision in different ways, influencing the demands and claims that become visible in the respective care arrangement. They differ in terms of the logics giving shape to them and the relations of inequalities embedded and contested in the two care arrangements, both leading to the rise of different demands and claims related to the respective life–care–work–housing nexus.

3.1. Demands and Claims in Live-In Care

In the face of demographic change, declining welfare states and eroding home-based gendered and intergenerational care provision by the family, the transnational brokerage of live-in care has become a stable pattern to marketise, formalise, standardise, legalise and thereby normalise and legitimise live-in care as an established and widely accepted, yet nonetheless contested pillar in the Austrian and German care regime and welfare state (Leiber & Österle, 2022; Leiber et al., 2020; Lutz & Schwiter, 2024; Steiner et al., 2019). In both countries, live-in care brokerage commercialises a formerly informally created care arrangement which is based on a mode of shuttle or circular migration: Two migrant carers live and work in the household of the care recipient alternating their presence at work in Austria or Germany and at home in the Central or Eastern European country they come from, e.g., Poland, Slovakia, Romania, Hungary or

Ukraine (Leiblfinger & Prieler, 2018; Lutz, 2018b; Palenga-Möllenbeck & Fiebig-Spindler, 2025; Weicht & Österle, 2016). As intermediators, brokerage agencies recruit and place the carers, and shape the care and working conditions directly or indirectly by their service provision, while the other parties involved, the care-recipients, their relatives, and the care workers, often informally, negotiate the everyday working conditions and care provision in the private household. Conflicting and contested demands and claims on decent or good care and work in terms of professionality and quality, fairness and justice, equality and recognition, autonomy and self-determination become evident in different dimensions of the hybrid and unequal live-in care arrangement (Aulenbacher et al., 2021; Emunds et al., 2022). We focus on the life–care–work–housing nexus: Live-in care links the ideal of ageing at home and seniors' self-determination with the privatisation of care responsibilities and with the commodification of care work within the household. As a result, live-in care is in line with the societal isolation of ageing in later life by taking privacy in charge for care responsibilities. The live-in of the care worker as its core element fuses workplace and living space (Lutz & Benazha, 2024).

Live-in care is part of the global mode of "extractivism of care" (Wichterich, 2016, p. 54), which indicates the appropriation and exploitation of care resources and labour force in the frame of newly interconnected trans—and international value and care chains (Lutz, 2018a; Palenga-Möllenbeck, 2024; Peng, 2024). Its life–care–work–housing nexus is created in the respective context of costs, profits, and wages. A pillar of the care regime and welfare state, directly or indirectly supported by federal and/or care allowances, live-in care addresses the middle classes in terms of income as well as of housing provision (lodge and board for the care workers in the household of the care recipient). Furthermore, in a "divided Europe" (Lutz, 2018b), live-in care is built upon the economic, prosperity, and wealth gaps between countries and regions in Western, Central, and Eastern Europe making the vulnerable female migrant workforce recruitable and thereby cheap labour available by also undermining working conditions in the receiving countries (Aulenbacher et al., 2020; Lutz, 2018b; Näre & Widding Isaksen, 2022). Herein, live-in care bridges two care gaps: On the one hand, in the private household, live-in care either substitutes family care or complements it (Emunds et al., 2022). It gives support to those care recipients in need who want to stay at home as part of their claim on a self-determined life in their given surroundings, but are not able to care for themselves. On the other hand, in the face of the austerity-driven social policy of declining welfare states, live-in care complements and substitutes more personnel-intensive, strictly regulated, and expensive care provision in residential care homes for seniors.

In this context, the transnational creation and supply of a vulnerable workforce is constitutive to brokered live-in care as a business model and affordable middle-class care arrangement. The profits generated by brokerage agencies are based on state-subsidised services combined with cheap labour. With regard to claims on good care and work, it is accompanied by the win-win-win ideologeme: care recipients gain support for a self-determined life at home, relatives benefit in terms of autonomy and relief, care workers gain income for a better life in their home countries (Schwiter et al., 2014). However, this argument neglects socio-spatial and social inequalities in Europe and between the parties involved (Schilliger et al., 2022) and thereby serves as a hidden legitimation of the contested live-in care arrangement. A closer look at this ideologeme shows that claims of the care recipients and their relatives in terms of gaining care, autonomy, and relief are embedded in and related to the standards of living in the receiving countries, while claims on better, equal, just, or fair pay of the care workers have to be argued against the grain of this transnational care arrangement. The implicitly ethnicising ideologeme relates the argument of good income to the wage

level of the sending countries, promising to improve the carers' living standard there, and ignores the constraints given by the living costs in the receiving countries, making living out impossible. Furthermore, this ideologeme is part of a broader discourse suggesting that there is no alternative to this low-cost mode of care provision (Weicht, 2016, p. 134) and legitimising poor working conditions through strategies of "othering" migrants (Palenga-Möllenbeck, 2022, pp. 4–5.) or by constructing the female migrant workforce as more or less appropriate to do the job under the given conditions (Prieler, 2021).

The life–care–work–housing nexus influences not only the costs and wages but also the working hours. In both countries, housekeeping, companionship, everyday life assistance, and, in Austria, in contrast to Germany, medical support (under special conditions) are all covered by live-in care, and brokerage agencies offer additional services like transport, supervision, and conflict mediation. Furthermore, live-in care is called and advertised as "24-hour-care" or "24/7" care provision. This suggests a more or less unlimited availability of the care workers, made possible by the life–care–work–housing nexus (Aulenbacher, Palenga-Möllenbeck, et al., 2025). In this context, we want to emphasize a two-fold demand of care recipients and their relatives: In line with the promises of brokerage agencies, both parties may expect that the carers provide good comprehensive care by subordinating their own life and work to the given order of the household and the demands and claims of the care recipient (Aulenbacher et al., 2021; Emunds, 2016; Lutz & Benazha, 2024). Furthermore, corresponding to the "24/7" promise, and related to the market logic of having paid for it, they may expect that live-in care workers will be prepared to work or be on call beyond the limitations regulated by law, contract, and/or more or less given standards of the brokerage industry (Aulenbacher, Palenga-Möllenbeck, et al., 2025). In everyday life, there is a risk that care workers will have unregulated working hours and unpaid overtime, especially if the care recipient has significant health problems such as dementia (Emunds et al., 2021, p. 6).

The flipside of the promise and claim on a self-determined ageing at home concerning the autonomy of the care recipient and the relatives is a high degree of heteronomy in the care workers' lives. It is embedded in the life–care–work–housing nexus inherent to this care arrangement and the respective demands. The care workers' unconditional claim on a limitation of their working time, enabling them not only to recover and thus maintain their own physical integrity, but also to realize their own wishes and pursue their own interests, which is codified in human rights, becomes precarious or even impossible (Emunds, 2024). Claims become more of a subject for interpersonal informal negotiations between the parties involved and their goodwill than to rights and duties (Aulenbacher et al., 2021) and, in the logic of neoliberal governance, to individual responsibility (Prieler, 2021).

However, in the life–care–work–housing nexus, at least two vulnerable groups of persons meet: the seniors and the mostly female migrants. Brokerage agencies advertise live-in care as a custom-made 1:1 care arrangement that provides an appropriate substitute or complement to family and an alternative to residential care homes. Imagining intimacy and good interpersonal relations as the focus of live-in care overlooks the burden of hard work and the isolated privacy in the household (Aulenbacher et al., 2021; Lutz & Benazha, 2024). In terms of autonomy and heteronomy, this means that seniors experience becoming dependent on care as a loss of their capacity to conduct their own lives, i.e., as a far-reaching loss of autonomy (Rossow, 2021). From this standpoint, the claim to remain at home is part of the claim to continue with their self-determined lives. Relatives, in turn, are challenged by the seniors' declining ability to care for themselves and their partial loss of autonomy, and are often suddenly confronted with extreme demands

due to (perceived) family care obligations. The loss of autonomy of the care recipient is accompanied by the loss of autonomy of the relatives. Live-in care promises to compensate for both losses, more or less implicitly at the cost of the care workers' living and working conditions. As the private household is simultaneously a protected sphere of private life and a workplace with limited external oversight and regulation of care quality and working conditions, the vulnerability of seniors and mostly female migrants makes the live-in care arrangement and its inherently unequal relationships prone to violence, including mistreatment or sexual harassment (Ignatzi, 2014).

The term "distorted emancipation" emphasizes that the commodification of care "did not make private care public; it is still private within the private economy. Even if marketization creates certain possibilities for financial rewards of care, it institutionalizes a double misrecognition of care" (Uhde, 2016, p. 401): as both unpaid and paid work. In transnational live-in care, this "misrecognition" (Uhde, 2016) is experienced by the care workers in different ways. It actively influences—and in turn is influenced by—claims on equality and justice, redistribution, and recognition, such as the ambivalent (mis)recognition of the care workers' absence from and the remittances for their home country (Haidinger, 2013, pp. 68–76). Studies on the transnational life–care–work–housing nexus, concerning the one within the household in the workers' home country and the one within the care recipient's household in the receiving country, give insight into conflicting demands and claims. Transnational motherhood can be interpreted as a paradigmatic case of the reorganisation of everyday life and care in the face of conflicting demands and claims. Demands and claims are reinterpreted by care workers with regard to absence and presence and the respective forms of (digital) communication, short-term and long-term goals (e.g., emotion and intimacy in everyday life and earning money for the children's higher education), and they thus create new forms of long-distance motherhood (Haidinger, 2013, p. 152). No less related to the normative and institutional order of the society and the gendered division of labour (Bahna & Sekulová, 2019), the transnational arrangement lets female migrant care workers feel "guilty" in not meeting the demands and claims of decent or even good care for the children (Sekulová, 2013, p. 229). Finally, the public discourse on labour migration remains gendered, stigmatising transnational motherhood and its children as "Euro-orphans," with new emancipatory elements in the gendered division of labour only slowly emerging (Lutz, 2018b; Lutz & Palenga-Möllenbeck, 2014, p. 225). In other words, the invisible part of the live-in care arrangement is the reorganisation of the life–care–work–housing nexus of the care workers within their home countries with regard to the respective demands and claims in both countries (Bahna & Sekulová, 2019, pp. 194–115; Haidinger, 2013, pp. 148–242). Such demands and claims interrelate in the social practices in the care workers' own as well as the care recipient's household, consequently affecting both the care arrangements at home and abroad.

In the face of such constellations, live-in care constitutes a contested field of interest representation, involving the brokerage agencies as the most powerful lobbyists of the model, collective initiatives of live-in carers, and also organisations of relatives (Wojczewski et al., 2026). Given the demographic trends and in view of the developments in the welfare states over recent decades, it is unlikely that live-in care will quickly become obsolete. Labour and social policy is therefore addressed to regulate working conditions in the live-in care sector (Leiber & Österle, 2022), thereby creating the conditions that make good work and care in this field more likely; this includes interfering in the life–care–work–housing nexus. Instead of the "24/7" logic, a range of additional support by services, family members, or social networks could ensure a better handling of problems inherent to this mode of care provision: for example, by reducing working hours, breaking isolation, and offering professional care and cure. However, such an improvement of live-in care

stands in direct conflict with government efforts not to push for the expansion of affordable professional services by public funding.

Through the lenses of the ethics of care, live-in care itself needs to be regulated, which also includes the certification and control of brokerage agencies (Emunds et al., 2021), so that they can be held accountable not only for the quality of the service provided, but also for working conditions; this is linked, for example, to the payment of cash-for-care benefits. Another option for making live-in care fairer, in line with the claims of carers and care recipients, could be to expand municipal care centres, which, on the one hand, assess needs and, on the other, support the coordination of meeting those needs, thus taking on the complex task of case and care management. If everything is no longer in "one hand," a mix of services is needed in home care (Hagedorn et al., 2022). Live-in care can be provided only in accordance with labour, social, and human rights in a mix of professional outpatient, day, and short-term care services which interfere in the life–care–work–housing nexus.

3.2. Demands and Claims in Caring Communities

Caring communities, indicating here the umbrella term for hybrid communitarian approaches and practices of care, have, for over a decade (Klie, 2014; Wegleitner et al., 2015), represented local model projects and social-space-oriented initiatives and programmes dedicated to a forward-looking reorganisation of care and communal living, often with a focus on later life. Central to many of these initiatives is the attempt to reconnect everyday life, care, work, and housing in specific localities, rather than treating them as separate policy domains. Core motifs connecting this highly heterogeneous landscape include: understanding people as relational beings whose coexistence and social constitution are shaped by interdependence and care; the shared responsibility of all—citizens and professional services, civil society, and the state; the promotion of social belonging and co-creation; integrated care and support within the immediate living environment—neighbourhood, district, or municipality; and an orientation towards a just shaping of everyday social participation, health, and care (Sempach et al., 2023; Wegleitner & Schuchter, 2018, 2021). They thus address key socio-political challenges: from loneliness (not exclusively) among seniors, to socio-economic inequalities that marginalise specific groups (e.g., people with migration biographies or people experiencing homelessness), unequal health opportunities, socio-ecological issues, and tasks linked to demographic change. This shifts the organisation of care away from a purely professional, provision-driven model towards an understanding that care emerges within more complex, social-communicative constellations and networks of care relationships (Schuchter et al., 2021, p. 20).

This makes it apparent, first, that caring communities can be seen as a reaction to the negative side-effects of late-modern, neoliberal developments—individualisation and competition, commodification of life domains, fragmentation of social and health systems, ecological exploitation, and the neoliberal delegation of responsibility for a good life and care to individuals. Second, it reveals a heightened normative self-understanding that necessitates critical positioning. From this perspective, caring communities have been interpreted as an expression of "community capitalism" (van Dyk & Haubner, 2021), and a symptom of late-capitalist outsourcing of welfare and care responsibilities into the private sphere—delegated to citizens, predominantly women, through unpaid care, de-professionalisation trends, and precarity (e.g., part-time work, live-in care).

The field of caring communities has been shaped by distinct, interwoven lines of development that together frame its diverse practices and aspirations. The first line originates in Public Health and health promotion, emphasising local communities, settings, and structural conditions for healthy, self-determined lives, and extends to end-of-life care through compassionate cities (Kellehear, 2005) and compassionate communities (Wegleitner et al., 2015). A second line arises from senior care and integrated home care or nursing, where non-profit providers connect home support, networking, prevention, and bridging roles such as community health nurses. A third line comes from social work and quarters-based practice, bringing systemic attention to local care conditions, rights, labour standards (including live-in care), and risks of neoliberal instrumentalisation within familialistic care regimes (Fleischer, 2018, 2023). A fourth line is socio-ethical and care-political, drawing on relational care anthropology, the ethics of care, and care democracy (Tronto, 2013), linking local practice to agendas of a care revolution and care-centred economies (Knobloch et al., 2022; Meier-Gräwe et al., 2023; Thiessen et al., 2020; Winker, 2015), including care-activist efforts and municipal care councils (Dowling & Moser, 2024). A fifth line moves through urban and spatial planning and municipal development (Power & Williams, 2020), tying care to the design of housing and neighbourhood infrastructures—public space, mobility, proximity services—and to diverse communities and often cooperative reorganisations of living together (e.g., intergenerational and co-housing models), where the built environment and collective governance become levers for everyday care, participation, and ageing in later life. From this perspective, housing, everyday care practices, work biographies, and local infrastructures are treated as connected fields that must be shaped in an integrated way.

Across these lines, realisations span continua (Fröhlich et al., 2025; Knobloch et al., 2022; Sempach et al., 2023): from immediately care- and nursing-oriented to social-space moderation, networking, health promotion, prevention, awareness-building, and care-political activism; from primarily civil-society-led to professionally led; from target-group-specific to life-course and social-space oriented; from institutionalised offerings with continuous positions to decentralised, cooperative, or neighbourhood forms; and from permanent services to short-term project funding. Moreover, realisations range from explicit service provision to opening enabling spaces and participatory futures work, that is, participatory processes of imagining and planning future care and neighbourhood arrangements, and from "care-politically blind" to "care-politically centred" initiatives that foreground citizen participation, unfair care distribution, and care labour conditions. Depending on these different characteristics and local structures, the composition of paid and unpaid care work, the relationship between formal and informal care, the intertwining of care and housing, and potential systemic contradictions between claims and demands at different levels differ markedly.

Because caring communities operate as hybrid care arrangements at the intersection of everyday life and institutional systems, they make both types of expectations visible; citizens' normative claims to belonging, voice, and recognition sit alongside institutional demands and requirements for coordination, financing, professional standards, and spatial infrastructure. These expectations converge and collide along the axes of care, work, and housing. Citizens articulate claims to social belonging and meaningful participation in shaping local life and care (Kainradl et al., 2024, pp. 48–52); such claims, especially pronounced among seniors, seek spaces of encounter, recognition of lived experience, and real co-creation of local care arrangements, including intergenerational and intercultural ties. Yet demands embedded in caring community process design and settings—meeting times, venues, digital reliance, language regimes, participation formats—often produce unintended exclusions. These micro-settings also reveal how care, work obligations, and housing locations jointly shape who can participate. The micro-politics of who can attend, speak, and decide silently

filters out those with care burdens, mobility restrictions, precarious work, or migration biographies. Here, claims to inclusive belonging and equality encounter organisational and resourcing demands, revealing a structural tension (Wegleitner et al., 2025, pp. 666–667). Unless participation is designed as an enabling infrastructure, the distribution of unpaid care work remains gendered and classed (Raap et al., 2021).

In this life–care–work–housing nexus, the widely shared claim to self-determined ageing in later life collides with demands arising from structural disintegration, such as fragmented interfaces between social and health care, underfinanced home- and community-based services, siloed budgets, and missing locally anchored coordinating roles. In urban contexts, weak coupling to city planning, housing, and mobility constrains the promise of place; in rural contexts, distance and service gaps pose different barriers. Thus, the claim to self-determination requires demands to be met at the system level, in the sense of integrated, cross-sector funding and governance for nursing, social work, case/care management, social-space moderation, community health nursing, and assisted living; fair recognition and cushioning of informal care to avoid entrenched gendered pension gaps and classed inequalities.

The more tightly caring communities are embedded in existing structures, the more sustainable they appear (Stouthard, 2023), but the lower their transformative leverage and the higher the risk of reproducing unjust care cultures becomes (e.g., reliance on unpaid women's work, marginalising prevention). Conversely, decentralised "radical care" (Hobart & Kneese, 2020; Laufenberg, 2020) approaches stage alternatives and politicises care yet remains precariously dependent on short-term grants and volunteer labour, risking co-optation as gap-fillers for austerity.

Caring communities also occupy a fault line between care as a communal claim—belonging, support, and co-creation in and with the community—and care as an individualised right—the ability to choose, receive, and enforce entitlements (Fleischer, 2023). The communal claim typically relies on shared neighbourhood infrastructures, collective coordination, and place-based reciprocity; without these, participation, mutual support, and solidarity tend to remain sporadic. The individualised right, in turn, depends on clear standards, the ability to carry entitlements across different contexts, and professional assurances that limit arbitrariness. When these conditions are connected (local arrangements that can realise legally defined entitlements), care becomes more experiential and usable in everyday life as well as more dependable. When they diverge (communal belonging without enforceable rights, or rights without local enabling structures), care often shifts into unpaid household work and moral obligation, or remains a formal entitlement with limited practical reach.

In light of current society-wide developments and deepening cuts to welfare state systems and basic public services, it is likely that caring communities will face policy demands for cost-saving community solutions, based on conservative familialistic care provision (Gábriel & Katona, 2025) and opposed to claims on care democracy and transformation. On the demand side, municipalities and funders often instrumentalise caring communities to fill gaps without changing budgets, labour standards, or housing structures. On the claim side, care actors and activists call for fair redistribution of care, decent work, and publicly financed, place-based infrastructures (Thiessen et al., 2020).

In caring communities, the increasing indispensability of live-in care highlights the interplay of claims and demands. The work of live-in carers is integral to many local care arrangements; if the aim is self-determined

living at home, their roles and vulnerabilities must be recognised. This requires integrating live-in carers into local networks, improving working and living conditions, and addressing their marginalised, gendered, and transnationally precarious status (Wojczewski et al., 2026). In this context, a double movement is required. First, an immediate claim to recognition and protection of live-in carers as part of local care ecologies is necessary by implying concrete functional demands: inclusive case and care management as well as network practices that name responsibilities across agencies, care-networks, and households. Second, the shared claim to self-determined living at home should not rest on normalising exploitative live-in care arrangements. Normatively, a future-oriented claim to care justice rejects the naturalisation of exploitative roles as system-immanent and instead points towards integrated, well-financed home- and community-based services and fair employment standards that reduce the reliance on live-in care arrangements. Care should therefore be organized in such a way that live-in care provided under the given working conditions can be replaced in the life–care–work–housing nexus, shaped by new forms of local care provision and supported by the state.

4. Conclusion

In the face of shifting societal care responsibilities, live-in care and caring communities are similar cases. Their approaches tend to serve neoliberal governance in different ways. They allow externalising costs by privatising care burdens and responsibilities instead of politicising them. For a welfare state committed to an austerity agenda, both options may appear useful and serve to ease the burden. In the first case, the extractivist mode of care provision relies on the cheap labour of a vulnerable, mostly female migrant workforce handling increasingly precarious work that is seen as a substitute for family care and made available by brokerage. The life–care–work–housing nexus inherent to this mode of care provision guarantees its affordability and accessibility for the middle classes, and is a cost-saving solution for the welfare state. Paid care services remain affordable and financeable. In the second case, care burdens and care responsibilities are shifted onto volunteer workers. By demanding and making use of unpaid care and by activating volunteer work, the state attempts to relieve itself of the burden of expanding professional care infrastructures. Even more, caring community initiatives must be aware of this danger of instrumentalisation by austerity policies and resist it, since their original self-imposed goal is a politically ambitious transformation and change of care structures.

Regarding the claims on care and housing provision, they are decidedly different cases: live-in care is highly ambivalent with regard to claims on autonomy in the sense of a self-determined life for seniors. Its life–care–work–housing nexus fuses the promise of and claim on autonomy and living at home in later life by focusing on the private household as living space and locus of care and housing provision. Thus, it becomes part of the societal isolation of age and ageing in later life by its seclusion in privacy instead of inclusion in public everyday life. Conversely, caring communities take part in creating socio-spatial and social infrastructures of care and housing provision and social networks to include ageing in later life beyond the private household in the public sphere and hence create a contrasting life–care–work–housing nexus. While live-in care brokerage as a growing migration industry represents the economic shift in care and housing provision, caring communities, if considered not only as a civil society's initiative but as a social movement, potentially can push a political shift to require new forms of public responsibility for senior care provision.

In the context of neoliberalism and austerity-driven social policies in a declining welfare state, live-in care and caring communities bridge increasing care gaps in the face of demographic change. While live-in care as an extractivist and exploitative mode of care provision raises and increases care gaps (in the sending countries and surroundings of the migrant workers), caring communities claim, among other things, to be part of deliberative searches for solutions of more democratic care and housing provision. This constellation has led to initiatives crossing the borders between the two modes of care provision, perhaps finding new ways to conceptualise and develop more appropriate care and housing arrangements.

Acknowledgments

We thank Kira Binder for her supportive language editing and Noah Heinemann for his helpful work on the references. Ewa Palenga-Möllenbeck's kind invitation as PI of CareOrg and also in the name of her co-editors allowed us to contribute to this thematic issue; additional support was given by the Theological Faculty Paderborn and the University of Graz. We are grateful to two anonymous reviewers for their very appreciative detailed feedback and for the editors' trustful "go ahead."

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of Interests

The authors declare no conflict of interests.

LLMs Disclosure

As all authors are non-native speakers, DeepL Pro and InstaText were selectively used by some team members for translation and linguistic refinement of specific sections. These tools were accessed via professional accounts to ensure data confidentiality. The authors critically reviewed all suggestions and take full responsibility for the final manuscript.

References

Anderson, B., & Shutes, I. (Eds.). (2014). *Migration and care labour: Theory, Policy and Politics*. Palgrave Macmillan.

Atzmüller, R., Décieux, F., & Ferschli, B. (Eds.). (2023). *Ambivalenzen in der Transformation von Sozialpolitik und Wohlfahrtsstaat. Soziale Arbeit, Care, Rechtspopulismus und Migration.* Beltz Juventa.

Aulenbacher, B., Décieux, F., & Riegraf, B. (2018). Capitalism goes care: Elder and child care between market, state, profession, and family and questions of justice and inequality. *Equality, Diversity and Inclusion: An International Journal*, *37*(2), 347–360.

Aulenbacher, B., Leiblfinger, M., & Prieler, V. (2020). The promise of decent care and the problem of poor working conditions. Double movements around live-in care in Austria. *sozialpolitik.ch*, *2*, 1–21.

Aulenbacher, B., Leiblfinger, M., & Prieler, V. (2021). Anforderungen und Ansprüche in der Live-in-Betreuung. Oder: „…ab und zu denken wir uns, das ist eigentlich unmöglich." In B. Aulenbacher, H. Lutz, & K. Schwiter (Eds.), *Gute Sorge ohne gute Arbeit? Live-in-Care in Deutschland, Österreich und der Schweiz* (pp. 147–171). Beltz Juventa.

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Aulenbacher, B., Novy, A., Baumgartner, B., Fröhlich, V., & Volmary, H. (2025). Facing transformative change? Care and housing in Europe. *Berliner Journal*, *35*(3/4), 391–400.

Aulenbacher, B., Palenga-Möllenbeck, E., & Schwiter, K. (2025). Unbegrenzt verfügbar—begrenzt verhandelbar, Arbeitszeit als Kernkonflikt der Live-in-Betreuung. *WSI-Mitteilungen*, *78*(1), 38–46.

Bahna, M., & Sekulová, M. (2019). *Cross border care. Lessons from Central Europe.* Palgrave Macmillan.

Bourdieu, P. (1986). The forms of capital. In J. Richardson (Ed.), *Handbook of theory and research for the sociology of education* (pp. 241–58). Greenwood.

Chee, L. L. (2025). *Merchants of migrant domestic labour, recruitment agencies and neoliberal migration governance in Southeast Asia*. Springer.

Claridge, T. (2018). Functions of social capital—Bonding, bridging, linking. *Social Capital Research*, *20*(1), 1–7. https://doi.org/10.5281/zenodo.7993853

Dammayr, M. (2019). *Legitime Leistungspolitiken? Leistung, Gerechtigkeit und Kritik in der Altenpflege.* Beltz Juventa.

De Donder, L., Stegen, H., & Hoens, S. (2024). Caring neighbourhoods in Belgium: Lessons learned on the development, implementation and evaluation of 35 caring neighbourhood projects. *Palliative Care and Social Practice*, *18*. Advance online publication. https://doi.org/10.1177/26323524241246533

Dowling, E. (2021). *The care crisis: What caused it and how can we end it?* Verso.

Dowling, E., & Moser, M. (2024). *Gemeinsam Sorgearbeit organisieren. Care-Räte umsetzen. Ein Toolkit*. https://care-r.at/wp-content/uploads/2025/08/Care-Raete_Toolkit-1.pdf

Dubet, F. (2008). *Ungerechtigkeiten. Zum subjektiven Ungerechtigkeitsempfinden am Arbeitsplatz.* Hamburger Edition.

Emunds, B. (2016). Menschenunwürdige Pflegearbeit in deutschen Privathaushalten. Sozialethische Bemerkungen zu den Arbeitsverhältnissen mittel- und osteuropäischer Live-Ins. *Jahrbuch für Christliche Sozialwissenschaften*, *57*, 199–224.

Emunds, B. (2024). Ethical comments on the working-time regime of live-in care. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale. The transnational brokering of senior care in Europe* (235–248). Sage.

Emunds, B., Hagedorn, J., Heimbach-Steins, M., & Quaing, L. (2022). *Häusliche Pflegearbeit gerecht organisieren.* Beltz Juventa.

Emunds, B., Kocher, E., Habel, S., Pflug, R., Tschenker, T., & von Deetzen, V. (2021). *Gute Arbeit für Live-In-Care. Gestaltungsoptionen für Praxis und Politik* (Policy Paper NBI-Positionen 2021/2). https://nbi.sankt-georgen.de/assets/documents/cillas-\/-und_nbi-position-2021_2-live-in-care.pdf

Farris, S. R., & Marchetti, S. (2017). From the commodification to the corporatization of care: European perspectives and debates. *Social Politics: International Studies in Gender, State & Society*, *24*(2), 109–131.

Fleischer, E. (2018). Älter werden in Mieming—wo geht die Reise hin? Partizipative Sozialplanung in einer Tiroler Landgemeinde. *soziales_kapital*, *19*, 136–150.

Fleischer, E. (2023). Caring communities—Appell an den Gemeinsinn statt sozialer Rechte? In R. Sempach, C., Steinebach, & P. Zängl (Eds.), *Care schafft Community–Community braucht Care* (pp. 107–118). Springer.

Foroutan, N. (2021). *Die postmigrantische Gesellschaft: ein Versprechen der pluralen Demokratie*. transcript.

Fröhlich, V., Gábriel, D., & Pimminger, F. (2025). Caring communities and urban cultures of care for older people in Austria, Hungary, and the Netherlands. *Urban Planning*, *10*, Article 10038. https://doi.org/10.17645/up.10038

Gábriel, D., & Katona, N. (2025). Caring communities in senior care—Municipal practices and civic initiatives in rural Hungary. *Berliner Journal für Soziologie*, *35*, 597–612.

Grenier, A., Hatzifilalithis, S., Laliberte-Rudman, D., Kobayashi, K., Marier, P., & Phillipson, C. (2020). Precarity and aging: A scoping review. *The Gerontologist*, *60*(8), 620–632.

Hagedorn, J., Hänselmann, E., Emunds, B., & Heimbach-Steins, M. (2022). *Doppelte Personenzentrierung—Leitidee für den Leistungsmix in der häuslichen Versorgung* (Working Paper FAgsF Nr. 80 / ICS AP Nr. 17) https://nbi.sankt-georgen.de/assets/documents/policy-paper_nbi-ics_juli-2022-(1).pdf

Haidinger, B. (2013). *Hausfrau für zwei Länder sein. Zur Reproduktion des transnationalen Haushalts*. Westfälisches Dampfboot.

Hobart, H. I. J. K., & Kneese, T. (2020). Radical care. Survival strategies for uncertain times. *Social Text*, *38*(1), 1–16.

Hürtgen, S., & Voswinkel, S. (2014). *Nichtnormale Normalität? Anspruchslogiken aus der Arbeitnehmermitte*. Edition Sigma.

Huxel, K., Karakyali, J., Palenga-Möllenbeck, E., Schmidbauer, M., Shinozaki, K., Spies, T., Supik, L., & Tuider, E. (2021). *Postmigrantisch gelesen, Transnationalität, Gender, Care*. transcript.

Ignatzi, H. (2014). *Häusliche Altenpflege zwischen Legalität und Illegalität. Dargestellt am Beispiel polnischer Arbeitskräfte in deutschen Privathaushalten*. LIT.

Kainradl, A., Kukovetz, B., Pupic, D., Sprung, A., & Wegleitner, K. (2024). Social participation of older people with migration experiences through the lens of active citizenship and caring communities. *The Annual Review of Social Work and Social Pedagogy in Austria*, *1*, 37–58.

Karner, C., & Weicht, B. (Eds.). (2016). *The commonalities of global crises. Markets, communities and nostalgia*. Palgrave Macmillan.

Katona, N., & Melegh, A. (Eds.). (2020). *Towards a scarcity of care? Tensions and contradictions in transnational elderly care systems in central and eastern Europe*. Friedrich Ebert Stiftung.

Kellehear, A. (2005). *Compassionate cities: Public health and end-of-life care*. Routledge.

Kessl, F., & Schoneville, H. (Eds.). (2024). *Mitleidsökonomie*. Beltz Juventa.

Klie, T. (2014). *Wen kümmern die Alten? Auf dem Weg in eine sorgende Gesellschaft*. Pattloch.

Klinger, C. (2013). Krise war immer… Lebenssorge und geschlechtliche Arbeitsteilung in sozialphilosophischer und kapitalismuskritischer Perspektive. In E. Appelt, B. Aulenbacher, & A. Wetterer (Eds.), *Gesellschaft. Feministische Krisendiagnosen* (pp. 82–104). Westfälisches Dampfboot.

Knobloch, U., Theobald, H., Dengler, C., Kleinert, A. C., Gnadt, C., & Lehner, H. (2022). *Caring societies—Sorgende Gesellschaften: Neue Abhängigkeiten oder mehr Gerechtigkeit?* Beltz Juventa.

Kofman, E., & Raghuram, P. (2015). *Gendered migrations and global social reproduction*. Palgrave Macmillan.

Laufenberg, M. (2020). Radical Care und die Zukunft des Wohlfahrtsstaats: Konturen einer paradoxen Politik der Sorge. *BEHEMOTH: A Journal on Civilisation*, *13*(2), 99–120.

Leiber, S., & Österle, A. (2022). Formalisierung des Informellen. Die Regulierung der „24-Stunden-Betreuung" in Österreich und Deutschlan. *WSI-Mitteilungen*, *75*(5), 380–385.

Leiber, S., Rossow, V., Österle, A., & Frerk, T. (2020). Yet another black box: Brokering agencies in the evolving market for live-in migrant care work in Austria and Germany. *International Journal of Care and Caring*, *5*(2), 187–208.

Leiblfinger, M., & Prieler, V. (2018). *Elf Jahre 24-Stunden-Betreuung in Österreich. Eine Policy- und Regime-Analyse*. Katholische Privat-Universität Linz.

Lutz, H. (2018a). Care migration: The connectivity between care chains, care circulation and transnational social inequality. *Current Sociology*, *66*(4), 577–589.

Lutz, H. (2018b). *Die Hinterbühne der Care-Arbeit. Transnationale Perspektiven auf Care-Migration im geteilten Europa*. Beltz Juventa.

Lutz, H., & Benazha, A. (2024). At home with the employer? Contradictory notions of the care client's home as a workplace and living space. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 219–231). Sage.

Lutz, H., & Palenga-Möllenbeck, E. (2014). Care-Migrantinnen im geteilten Europa—Verbindungen und Widersprüche in einem transnationalen Raum. In B. Aulenbacher, B. Riegraf, & H. Theobald (Eds.), *Sorge: Arbeit, Verhältnisse, Regime / Care: Work, relations, regimes* (pp. 217–231). Nomos.

Lutz, H., & Schwiter, K. (2024). Umkämpfte Formalisierung und Normalisierung der Live-in-Betreuung. Zur Vermarktlichung von Care-Arbeit im „sorglosen Kapitalismus." In R. Atzmüller, K. Binner, F. Décieux, R. Deindl, J. Grubner, & K. Kreissl (Eds.), *Gesellschaft in Transformation, Sorge, Kämpfe und Kapitalismus* (pp. 68–78). Beltz Juventa.

Lynch, K. (2021). *Care and capitalism*. John Wiley & Sons.

Meier-Gräwe, U., Praetorius, I., & Tecklenburg, F. (Eds.). (2023). *Wirtschaft neu ausrichten. Care-Initiativen in Deutschland, Österreich und der Schweiz*. Barbara Budrich.

Melegh, A. (2023). *The migration turn and Eastern Europe, a global historical sociological analysis*. Palgrave Macmillan.

Näre, L., & Widding Isaksen, L. (2022). *Care loops and mobilities in Nordic, Western and Eastern European welfare states*. Palgrave Macmillan.

Pahl, R. E. (1984). *Divisions of labour*. Basil Blackwell.

Palenga-Möllenbeck, E. (2022). Making migrants' input invisible: Intersections of privilege and otherness. *Social Inclusion*, *10*(1), 183–194.

Palenga-Möllenbeck, E. (2024). Divided Europe? The role of home care agencies from Poland, and how the ideal of decent work gets lost along transnational value chains. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale, the transnational brokering of senior care in Europe* (pp. 23–36). Sage.

Palenga-Möllenbeck, E., & Fiebig-Spindler, R. (2025). Emerging home care markets in Central and Eastern Europe: Transformations of senior care, labour mobility, and housing in Poland and Germany. *Berliner Journal für Soziologie*, *35*(1), 549–564.

Peng, I. (2024). Brokering care migration—A new element in the transnational care worker supply chain. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale, the transnational brokering of senior care in Europe* (pp. 295–310). Sage.

Power, E. R., & Williams, M. J. (2020). Cities of care: A platform for urban geographical care research. *Geography Compass*, *14*(1), Article 12474. https://doi.org/10.1111/gec3.12474

Prieler, V. (2021). "The good live-in care worker": Subject formation and ethnicisation in Austrian live-in care. *Sociológia: Slovak Sociological Review*, *53*(5), 483–501.

Putnam, R. D. (1994). Social capital and public affairs. *Bulletin of the American Academy of Arts and Sciences*, *47*(8), 5–19.

Raap, S., Knibbe, M., & Horstman, K. (2021). Caring neighbourhoods: Maintaining collective care under neoliberal care reforms. *European Journal of Social Work*, *25*(5), 867–879.

Roller, K., Rudolph, C., Eck, S., Schneider, K., & Vischer, N. (2024). *Wohnen, Care, Geschlecht—Theorie und Praxis kollektiven Wohnens aus Geschlechterperspektive*. Westfälisches Dampfboot.

Roller, K., & Schneider, K. (2024). Orte der Sorge, Zu Care und Geschlecht in gemeinschaftlichen Wohnprojekten. In K. Roller, C. Rudolph, S. Eck, K. Schneider, & N. Vischer (Eds.), *Wohnen, Care, Geschlecht—Theorie und Praxis kollektiven Wohnens aus Geschlechterperspektive* (pp. 10–25). Westfälisches Dampfboot.

Römhild, R. (2017). Beyond the bounds of the ethnic: For postmigrant cultural and social research. *Journal of Aesthetics & Culture*, *9*(2), 69–75.

Rossow, V. (2021). *Der Preis der Autonomie. Wie sorgende Angehörige Live-in-Arbeitsverhältnisse ausgestalten*. Barbara Budrich.

Rudolph, C., & Schmitt, K. (Eds.). (2019). *Interessenvertretung und Care, Voraussetzungen, Akteure und Handlungsebenen*. Westfälisches Dampfboot.

Schilliger, S., Schwiter, K., & Steiner, J. (2022). Care crises and care fixes under Covid-19: The example of transnational live-in care work. *Social & Cultural Geography*, *24*(3/4), 391–408. https://doi.org/10.1080/14649365.2022.2073608

Schuchter, P., Wegleitner, K., & Heller, A. (2021). Ethik in der kommunalen Sorge: Lebenskunst und ethische Spannungsfelder. In A. Riedel & S. Lehmeyer (Eds.), *Ethik im Gesundheitswesen*. Springer. https://doi.org/10.1007/978-3-662-58685-3_59-1

Schwiter, K., Berndt, C., & Schilling, L. (2014). Ein sorgender Markt, Wie transnationale Vermittlungsagenturen für Seniorenbetreuung, Im/mobilität, Ethnizität und Geschlecht in Wert setzen. *Geographische Zeitschrift*, *102*(4), 212–231.

Sekulová, M. (2013). Transnational households in the context of female migration from Slovakia to Austria. In *Urban People/Lidé Mesta*, *15*(2), 217–236.

Sempach, R., Steinebach, C., & Zängl, P. (Eds.). (2023). *Care schafft Community-Community braucht Care*. Springer.

Steiner, J., Prieler, V., Leiblfinger, M., & Benazha, A. (2019). Völlig legal!? Rechtliche Rahmung und Legalitätsnarrative in der 24h-Betreuung in Deutschland, Österreich und der Schweiz. *Österreichische Zeitschrift für Soziologie*, *44*(1), 1–19.

Stouthard, L. (2023). How caring communities become part of the health system of the future in the Netherlands: Developments, bottlenecks, and impact. *International Journal of Integrated Care*, *23*(1), Article 96. https://doi.org/10.5334/ijic.ICIC23036

Thiessen, B., Weicht, B., Rerrich, M. S., Luck, F., Jurczyk, K., Gather, C., Fleischer, E., & Brückner, M. (2020). *Großputz! Care nach Corona neu gestalten. Ein Positionspapier zur Care-Krise aus Deutschland, Österreich, Schweiz*. https://care-macht-mehr.com/wp-content/uploads/2022/11/2020_08_13_Manifest-Care.macht_.mehr_final.pdf

Thornton, P. H., Ocasio, W., & Lounsbury, M. (2012). *The institutional logics perspective. A new approach to culture, structure, and process*. Oxford University Press.

Tronto, J. C. (2013). *Caring democracy. Markets, equality, and justice*. New York University Press.

Tronto, J. C. (2025). Afterword: The centrality of housing for good care. *Berliner Journal für Soziologie*, *35*, 691–703.

Uhde, Z. (2016). From women's struggles to distorted emancipation. *International Feminist Journal of Politics*, *18*(3), 390–408. https://doi.org/10.1080/14616742.2015.1121603

van Dyk, S. (2025). Engagierte und Communities als Lückenbüßer in Zeiten fragiler sozialstaatlicher Solidarität. *Amos international*, *19*(4), 22–31.

van Dyk, S., Graefe, S., & Lorig, P. (2026). Freiwilligkeit im Gegenwartskapitalismus—Ein soziologisch inspirierter Streifzug. In P. Schink & P. Lorig (Eds.), *Freiwilligkeit. Eine Spurensuche in Geschichte und Gegenwart* (pp. 123–143). transcript.

van Dyk, S., & Haubner, T. (2021). *Community-Kapitalismus*. Hamburger Edition.

Walsh, K., Scharf, T., Van Regenmortel, S., & Wanka, A. (Eds.). (2021). *Social exclusion in later life. Interdisciplinary and policy perspectives*. Springer.

Wegleitner, K., Heimerl, K., & Kellehear, A. (Eds.). (2015). *Compassionate communities: Case studies from Britain and Europe*. Routledge.

Wegleitner, K., & Schuchter, P. (2018). Caring communities as collective learning process: Findings and lessons learned from a participatory research project in Austria. *Annals of Palliative Medicine*, *7*(2), 84–98.

Wegleitner, K., & Schuchter, P. (2021). *Handbuch Caring Communities—Sorgenetze stärken—Solidarität leben*. Österreichisches Rotes Kreuz.

Wegleitner, K., Sprung, A., Kainradl, A.-C., Pupić, D., Kukovetz, B., & Kriebernegg, U. (2025). Social participation and active citizenship of older adults in caring neighbourhoods: Insights from the inter- and transdisciplinary project Caring-Living-Labs Graz. *Berliner Journal für Soziologie*, *35*, 651–672.

Weicht, B. (2016). Die einzige Möglichkeit: Die 24-Stunden-Betreuung aus diskursiver Perspektive. In B. Weicht & A. Österle (Eds.), *Im Ausland zu Hause pflegen. Die Beschäftigung von MigrantInnen in der 24-Stunden-Betreuung* (pp. 115–138). LIT.

Weicht, B., & Österle, A. (Eds.). (2016). *Im Ausland zu Hause pflegen. Die Beschäftigung von MigrantInnen in der 24-Stunden-Betreuung*. LIT.

Wichterich, C. (2016). Feministische Internationale Politische Ökonomie und Sorgeextraktivismus. In U. Brand, H. Schwenken, & J. Wullweber (Eds.): *Globalisierung analysieren, kritisieren und verändern. Das Projekt Kritische Wissenschaft. Christoph Scherrer zum 60. Geburtstag* (pp. 54–71). VSA.

Williams, F. (2011). Towards a transnational analysis of the political economy of care. In R. Mahon & F. Robinson (Eds.), *Feminist ethics and social policy, towards a global economy of care*. UBC Press.

Winker, G. (2015). *Care revolution: Schritte in eine solidarische Gesellschaft*. transcript.

Wojczewski, S., Nagy, F., & Durisova, S. (2026). Shaping home care in community: Social networking between migrant live-in careworkers and family caregivers. A case study in Austria. *Geriatric Nursing*, *69*, Article 103898. https://doi.org/10.1016/j.gerinurse.2026.103898

Yeates, N. (2009). *Globalizing care economies and migrant workers. Explorations in global care chains*. Palgrave Macmillan.

About the Authors

Brigitte Aulenbacher is a sociologist and retired professor at the Johannes Kepler University Linz, Austria. In her empirical research, she investigates the marketisation, digitalisation, and organisation of senior care and care work. In her theoretical work, she contributes to the feminist and intersectional analysis of contemporary capitalism.

Klaus Wegleitner is a sociologist and care researcher. As an associate professor at the University of Graz, Austria (at the Center for Interdisciplinary Research on Aging and Care and the Institute for Pastoral Theology), his research focuses on the societal organisation of care and solidarity networks, public health end-of-life care, and caring communities.

Jonas Hagedorn is a theologian and political scientist. He is a professor of Christian social ethics at the Theological Faculty Paderborn, Germany. The focus of his research projects is on the development of welfare states, social policies, and care work, the international recruitment of healthcare professionals, the concepts of solidarity and subsidiarity, and the foundations of social ethics.

Bernhard Emunds is an economist and theologian. He is a professor of Christian social ethics at the Sankt Georgen Graduate School of Philosophy and Theology in Frankfurt (Main), Germany, where he also heads the Nell-Breuning Institute. His research focuses on the ethics of finance, social policy, gainful and care work, and the foundations of economic ethics.

Social Inclusion
2026 • Volume 14 • Article 12319
https://doi.org/10.17645/si.12319

cogitatio

ARTICLE

Open Access Journal

Care Outsourcing From Germany to Central and Eastern Europe

Kristine Krause [1], Veronika Prieler [1], Hanna Horváth [1], Matouš Jelínek [1], Mariusz Sapieha [1], Zuzana Sekeráková Búriková [2], Petra Ezzeddine [3], and Luise Schurian-Dąbrowska [4]

[1] Department of Anthropology, University of Amsterdam, The Netherlands
[2] Institute for Sociology, Slovak Academy of Sciences, Slovakia
[3] Department of Social and Cultural Anthropology, Charles University, Czech Republic
[4] Swiss Academy for Development, Switzerland

Correspondence: Kristine Krause (k.krause@uva.nl)

Submitted: 3 March 2026 **Accepted:** 27 April 2026 **Published:** 3 June 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

The transnational care market in Europe is commonly understood as the migration of (mostly) female care workers from East to West. Less attention has been paid to a reverse mobility: older persons relocating from West to East in search of more affordable care. This article presents research on care homes in Poland, the Czech Republic, Slovakia, and Hungary that cater both to local, relatively wealthy seniors and to clients from Germany who move there for care at roughly one-third of German prices. Although the numbers of such relocated seniors remain low and do not provide a structural solution to Germany's care crisis, this trend is emblematic of the intensified marketisation of care in Germany and in the receiving countries. It constitutes a distinct formation of exclusive marketisation (available only for those who can afford it) within the evolving European transnational care market. We argue that grasping the multifaceted nature of care outsourcing requires analysing how it is entangled with other forms of mobility and entrepreneurial projects, for example in tourism or construction. By shifting the analysis from Western Europe to the Central and Eastern European (CEE) region, we seek to avoid reproducing power geometries that cast CEE primarily as a reservoir of cheap care labour or as a socio-economically "deprived" dumping ground for Western problems. Our research underscores the importance of actors beyond family and state in transnational care arrangements and shows how ambiguous German–CEE histories call for a regional, historically attuned perspective on care in an unequal Europe.

Keywords

care outsourcing; care relocation; Central and Eastern Europe; exclusive marketisation; long-term care; regional history; transnational care

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Due to the introduction of cash-for-care schemes in many Western European countries in the 1990s (Da Roit et al., 2016), and the opening of the Iron Curtain, a transnational care market has emerged in Europe. In this market, care labour is predominantly brokered from countries in Central and Eastern Europe (CEE) to Western Europe (Aulenbacher et al., 2024). Reflecting a pattern also observed globally (Peng, 2024), the transnationalisation of care is therefore primarily understood as the migration of (mostly) female care workers from economically weaker to economically stronger regions (Michel & Peng, 2017).

The reverse movement, the relocation of older persons in need of care to more affordable destinations, remains far less common. While this form of care outsourcing has been examined mainly in Asian contexts (Horn et al., 2016; Johnston & Pratt, 2022; Ormond & Toyota, 2016; Pratt & Johnston, 2022) and the global South (Schweppe, 2022), its European variant is shaped by a distinctive constellation: the rights associated with European citizenship, including the portability of pensions and care entitlements (Dwyer, 2001; Horn & Schweppe, 2017), and persistent socio-economic hierarchies between Western Europe and CEE countries (Gábriel, 2022; Lewicki, 2023; Lewicki & Probst, 2026; Palenga-Möllenbeck, 2022; Uhde & Ezzeddine, 2019).

Moreover, the infrastructure that facilitates the relocation of older persons for care within Europe is closely intertwined with established channels of care worker migration (Aulenbacher et al., 2024; Prieler, 2024). For this reason, even though the relocation of care recipients remains limited in scale, it should be understood as an integral component of the broader transnational European care market that this thematic issue examines.

In this article, we present results from a multi-sited ethnographic study into care relocation from Germany to the Czech Republic, Slovakia, Hungary, and Poland. In these countries, a small number of entrepreneurs, ranging from family businesses to medium-sized national companies and international investment firms, reach beyond national borders to recruit customers, offering care at roughly one-third of the cost of similar institutions in Germany.

The limited research on care outsourcing to CEE has largely focused on the precarity of older German people (Ormond & Toyota, 2016) and on the needs of families seeking solutions to their care challenges (Bender et al., 2018; Horn et al., 2016). Analysing debates in German-language media, Schwiter et al. (2020) show how the outsourcing of care for vulnerable seniors is scandalised, while the extraction of a migrant live-in care workforce is normalised. Western seniors appear as legitimate subjects of care, whereas care workers are reduced to a labour resource whose own family relationships and care needs are overlooked (Uhde & Ezzeddine, 2019). Großmann and Schweppe (2020) examine the legitimisation strategies of Polish care entrepreneurs who market their facilities as "just like in Germany, only better" (p. 823), and ethicists have discussed the dilemmas of outsourcing care to lower-income countries (Bally-Zenger et al., 2017; de Vries, 2021).

Overall, these studies conclude that the actual number of older adults relocated from Germany to receive care in lower-income settings within Europe is too small either to resolve Germany's care needs or to affect care capacities in the receiving countries. On that basis, one might conclude there is little more to say about care outsourcing. Yet new care homes are opened and continue to advertise their services. This prompted us,

at the outset of the project, to ask how care for older Germans is embedded in other sectors, aspirations, and entrepreneurial projects. To do so, we adopted a perspective from within the CEE region itself, asking: (a) How are care homes serving German-speaking seniors embedded in local CEE care landscapes? (b) How does care outsourcing intersect with other forms of mobility, entrepreneurial activity, and intimate outsourcing related to care and labour? and (c) How do these arrangements and practices unfold while situated within the hierarchical East–West relations that structure Europe? (Lewicki & Probst, 2026, p. 43). We argue that understanding care outsourcing requires shifting the analytical lens from Western Europe to CEE (Jelínek, 2025a, 2025b, 2026; Jelínek & Krause, 2026; Sapieha, 2026b). Doing so reveals that the common image of care homes catering exclusively to German clients is misleading. It obscures the diversity and complexity of transnational care arrangements in the region, which involve not only German seniors but also local older adults, both with and without transnational ties.

2. A Regional Perspective on Marketised Care Landscapes and Regimes

In claiming a regional perspective, we do not conceptualise regions to simply exist on a current map, but as a historical "product of networked flows and relations fixed in a more or less provisional manner" (Allen & Cochrane, 2007, p. 1162). In the case of CEE, these flows and relations include long-standing migration movements, shifting and contested borders, shared histories of belonging to different empires (Habsburg, Russian, Prussian) and to the Eastern bloc, relatively low positioning within EU economic hierarchies, and the framing of the area as a "less-developed" region through EU policies and development programmes.

Milligan and Wiles' (2010) landscapes of care and Williams' (2018) notion of care regimes help us to capture this complexity, including its historical layers. Care landscapes, as Milligan and Wiles (2010, p. 739) define them, are the spatial expression of the socio-structural forces that shape how care is experienced and practised. Williams (2018, p. 552) similarly understands care regimes as the intersection of policies, regulations, conditions, cultures, legacies, and power relations that organise care in society. Sciortino (2004) adds that regimes are contingent rather than planned: They emerge from implicit conceptual frames, bureaucratic turf wars, and successive "quick fixes" to emergencies triggered by shifting political constellations (pp. 32–33). Regimes and care landscapes are therefore the ongoing product of practical "repair work" (Sciortino, 2004, pp. 32–33).

Care outsourcing is one such form of repair. Enabled by national social policies and European social rights legislation—though not directly intended by either—it reflects broader transformations of care regimes under austerity and marketisation (Aulenbacher et al., 2018; Dahl, 2017). It functions as a typical "fix" in Dowling's (2022, p. 15) sense: a response to care gaps that becomes a business opportunity without resolving underlying structural problems. It also aligns with the wider processes of commodification, marketisation, and corporatisation of care described by Farris and Marchetti (2017, p. 123), in which states retreat from direct provision and large for-profit companies dominate, corporatising care.

In CEE, however, fragmented and institutionally weak care regimes leave little room for major corporate providers. The sector is shaped instead by small and medium-sized actors whose activities reflect forms of "entrepreneurialism" (Sapieha, 2026b) targeting "exclusive" clients. This "entrepreneurial turn" (Sapieha, 2026b) is driven less by strategic planning (Safuta, 2021) and more by the opportunistic seizing of emerging openings. Care outsourcing to CEE both feeds into and crystallises these dynamics and is emblematic of

"exclusive marketisation": Care is organised through market mechanisms but remains accessible only to those who can pay, deepening inequalities in access. This contrasts with "inclusive marketisation," where markets exist but are strongly regulated and subsidised (Chatzidakis et al., 2025).

3. Methods

This article draws on multi-sited ethnographic research conducted in several stages and in changing researcher constellations. Pilot research by Sapieha and Krause (2017–2019), later joined by Schurian-Dąbrowska (2019) and a consortium including Ezzeddine and Búriková (2020), prepared the ground for the main study (2021–2025), funded by the ERC Starting Grant "ReloCare" and conducted by Krause, Sapieha, and Jelínek together with Prieler and Horváth.

The research followed a three-stage design. In the first phase, we tried to establish the number of homes in Poland, Czech Republic, Slovakia, and Hungary offering care services to clients from Germany by comparing their online presence with results from calling them up and checking whether they currently had, had previously had, or planned to have German-speaking residents. We searched online using German terms such as "Pflegeheim" (nursing home) and "(Alten-)Pflege im Ausland" (senior care abroad), combined with country names, identifying both individual homes and German-language platforms listing homes abroad. We complemented this with further online research in local languages to gather information on each home and its context, including checks in chambers of commerce. The second stage involved on-site visits to identified homes. In total, we visited 32 homes and conducted 88 in-depth interviews with owners and managers, care workers, intermediary agencies, seniors and relatives, and public authorities.

In the third research stage, we carried out in-depth participant observation in five homes. Covid-19 restrictions and differing fieldwork durations meant that the depth of data collected varies across the four countries. Repeated, long-term field visits took place in three homes in Poland (Sapieha, 2026a, 2026b; Schurian-Dąbrowska, 2019), two in the Czech Republic (Jelínek, 2025b; Jelínek & Krause, 2026), and one in Hungary (Prieler et al., 2026).

The research questions focused on daily life in the care home (Schurian-Dąbrowska, 2019), including the role of language (Jelínek, 2025a; Schurian-Dąbrowska & Krause, 2023), entrepreneurial and regional logics (Jelínek, 2025b, 2026; Sapieha, 2026b), and the articulation of regional histories in care outsourcing (Jelínek & Krause, 2026; Sapieha, 2026a). As part of their PhD projects, Sapieha and Jelínek followed selected homes closely over several years, at times joined by Krause. In 2023, Prieler, Horváth, and Krause conducted joint fieldwork in Hungary, and Krause and Prieler also interviewed family members (mainly by phone). Based on the results from the first and second research phases, we did not conduct in-depth fieldwork in Slovakia, as our mapping suggested that the number of German residents had declined there after an initial peak.

At every research stage, whenever possible, we made calls and visits collaboratively, combining our language skills and different regional sensitivities. The research generated materials which include multilingual interviews, shared fieldwork descriptions in English, notes from navigating care homes' online presence, and visual materials, especially on buildings and the embeddedness of homes in their local surroundings (Sapieha, 2026a). In line with ethnographic practice, we treated data collection and analysis as an intertwined process that continuously reshaped each other (Ballestero & Ross Winthereik, 2021).

4. Results

4.1. Entrepreneurial Actors in Fragmented Care Landscapes

The long-term care systems in Poland (Czepulis-Rutkowska, 2017; Safuta, 2021), the Czech Republic (Dudová, 2018; Souralová & Šlesingerová, 2017), Slovakia (Káčerová et al., 2021; Szüdi et al., 2016), and Hungary (Gál, 2017; Gyarmati, 2019) share forms of fragmentation and tension between social and health care (Social Protection Committee, 2021; Spasova et al., 2018). Although there are local specificities, they are all essentially based on informal care work, performed mostly by female family members, whose work is invisibilised in current political discussions (van Horen et al., 2026). Societal ageing, women's labour market participation, and changing family structures put these familial care regimes increasingly under pressure. At the same time, the expansion of public long-term care provision and funding has been slow or has not happened at all. As a result, considerable shortages in home care and residential care services can be observed across all four countries studied, as reflected in unmet care needs and waiting periods of up to a year or longer for a care home place (Gyarmati, 2019). The shortages of places are also linked to workforce shortages caused by (circular) outmigration of care workers to Western European countries (see e.g., Katona & Zacharenko, 2021) and bad working conditions within the care sector, including low social recognition and remuneration. Thus, while previously serving mainly as sending countries of care workers, in particular Poland and the Czech Republic have become receiving countries, mainly from Ukraine (Kindler, 2008).

Within the care landscapes of the four countries, private entrepreneurs have entered the scene, shaping the care market and filling gaps for those who can afford to pay for it. Processes which in other European countries took several decades have happened in CEE countries over a shorter time period (Sapieha, 2026b). It is within this accelerated market development context that the care homes which recruit customers across the border from Germany are situated.

These homes tap into a gap in the German care regime by offering institutional care at roughly a third of the cost in Germany, making it potentially attractive for families who must supplement statutory care insurance with out-of-pocket contributions that frequently exceed €3,000 per month. Older persons are entitled to a care allowance based on assessed need (Theobald, 2012), which, together with their pension and health insurance, can be carried across borders (Dwyer, 2001). Yet despite these systemic incentives, the actual number of seniors who relocate to CEE countries remains lower than available capacities, even as individual homes maintain waiting lists.

4.2. Numbers and Diversity of Relocated Seniors

Our mapping shows what earlier studies have also found: The number of German seniors receiving care in CEE countries is far lower than media debates and online listings suggest (cf. Großmann & Schweppe, 2020, p. 830–831). We estimate that around 1,500 people from Germany and to a small extent from Switzerland have relocated for care in CEE countries between 2019 and 2024, but numbers fluctuate. Previous studies have argued as well that the precise number is difficult to establish. Like Großmann and Schweppe (2020) in their study on Poland, we came across several homes that had stopped recruiting German seniors, but also others which had great ambitions and were just beginning such recruitment.

Throughout the duration of the project, we came into contact with and confirmed a total of 33 institutions that had German-speaking clients. This is much lower than what we found on the internet beforehand: around 128 facilities advertising their services in German or on German-language platforms (Table 1).

Overall, the numbers need to be treated with caution. We were relying on the homes' self-reported figures, and were not able to cross-check with their records. Also, who among their clients the owners or employees considered German or just German-speaking depended on the respondents' understanding of Germanness (see Sections 4.6 and 4.7). Furthermore, it can be assumed that the number of homes and seniors hosted in them might have changed again by the time this article is published.

Table 1. Mapping results: number of care homes and relocated residents (2020–2024).

Country	Care homes listed online	Care homes caring for relocated seniors	Exclusively or mainly German-speaking residents	Care homes that had stopped caring for relocated seniors	Estimated capacity in absolute numbers
Poland	63	9	2	9	ca. 400
Czech Republic	19	8	2	3	ca. 300
Slovakia	17	5		5	None at time of research
Hungary	29	11	1	5	ca. 200–300
Total	128	33	5	22	ca. 900–1000

All care homes were owned and operated by private, commercial companies or non-profit organisations and had registered as senior care facilities in the respective countries. Some of them had contracts with the national health insurances or were part of regional social care networks, others catered exclusively to privately paying clients.

Across all the countries we studied—especially in the Czech Republic and Poland—care homes were located in less developed regions. Care entrepreneurs drew on targeted EU regional development programmes, which also aim to strengthen long-term care. These programmes provided funding to build or refurbish facilities serving both local residents and EU citizens.

The older Germans we met were heterogeneous in age, health condition, degree of decision-making involvement, financial background, and family situation. There was also diversity in family backgrounds: Some had spouses and extended families back home, while others had no involved relatives at all—a few even requiring state-assigned guardians to arrange their relocation. Occupational backgrounds varied widely, from electricians and truck drivers to teachers and civil servants. Overall, we could not identify a clear relationship between socio-economic background and the decision to relocate. Less surprising was the socio-economic pattern across facilities: Homes with monthly fees below €2,000 tended to host a larger share of residents from lower-income backgrounds, while those charging higher fees—up to €3,000—and offering a more favourable staff-to-resident ratio or more extensive services attracted more affluent clients.

4.3. German Customers as Part of Innovative (Interim) Business Strategies

Catering for local as well as foreign clients seemed for some homes to be a business strategy to balance fluctuating demand, and also responded to specific developments in the respective care regimes. In Slovakia, for instance, Búriková found that although publicly run facilities remained the most important type of provider and accounted for more than three-quarters of care home places, an increase in private care homes (from around 25 percent of clients in 2006 to around 55 percent in 2017) was closely linked to the amendment of the Social Services Act, put into practice from January 2011. Before the amendment, only public providers had been eligible for subsidies. Due to the amendment, non-profit but non-state providers could also apply for public subsidies, which drove the emergence of non-profit care homes, whose managers however would have preferred running for-profit companies, as they told Búriková in her interviews (conducted 2021). During this transition process, foreign clients played an interesting role. As it took some time to rearrange the payment of subsidies and because the vast majority of Slovak clients could not afford market prices, foreign clients were crucial because they provided much-needed cash during a financially insecure time. As soon as the private care homes had enough subsidised local clients, care entrepreneurs were no longer keen to accept foreign clients as they led to more work, mainly related to the need to navigate different national care bureaucracies.

Similarly in Poland, Sapieha followed entrepreneurs who experimented with the gaps available in the unsettled Polish care market, given the limited availability of state institutional care (Wrotek & Kalbarczyk, 2025). Targeting older persons with severe care needs from Germany has become one of these commercial experiments, often piggybacking on agencies that are specialised in sending live-in carers to Germany (Sapieha, 2026b).

In Hungary, where the few available publicly-funded care institutions are run by municipalities or churches, Horváth, Prieler, and Sapieha found in 2022 a wide variety of commercial care homes catering to seniors relocated from Germany. Small care entrepreneurs house only two or three older persons in their private homes, while larger facilities accommodate between 60 and 100 residents, including assisted living arrangements (Prieler et al., 2026). Alongside clients from Germany and Switzerland, these larger facilities also target more affluent Hungarians who spent most of their working lives in higher-income countries and consequently have greater financial resources to fund their care in later life.

While most care homes in which we could conduct fieldwork were small-scale homes ranging from ca. 16 to 80 residents, in the Czech Republic and Poland large transnational companies are starting to enter the sector, such as the French publicly listed company Orpéa/SeneCura (KPMG, 2021, p. 51). In the Czech Republic, Ezzeddine learned from experts and union representatives (interviews conducted 2021) that these players have started to shape the residential care sector, particularly with regard to professionalisation and negotiating wages and standards—an example of what Farris and Marchetti (2017) identified as the "corporatization of care."

4.4. Challenges and Reasons to Stop

Relocating to a care home abroad is a significant decision carrying substantial challenges for seniors, relatives, and providers alike. In the case of Slovakia, care entrepreneurs decided to stop serving foreign customers after their private businesses had consolidated, and due to the extra workload which accompanies foreign

clients. This pattern also appeared in other countries. Care home managers and care workers complained about heavier workload due to the additional administration such as registering residents with the municipality, or sending reports to the insurance company to sort out payments. In some cases, intermediary agencies deliver part of that work. Communication challenges in day-to-day care work were common, especially where language barriers existed between residents and staff (Schurian-Dąbrowska & Krause, 2023). While trained care professionals are accustomed to navigating difficult communication, many workers in these facilities are care assistants who receive most of their training on the job. They often rely on rudimentary German skills acquired during periods of work abroad. Even so, communication difficulties, with both residents and their family members, emerged as a recurring issue across all countries studied. In Poland, larger facilities employ dedicated staff to manage communication with relatives, while smaller ones must make do with whatever resources they have.

Across all four countries, interviews and calls consistently revealed that the health status of incoming seniors is often far more severe than care homes had anticipated based on declarations by relatives or intermediary agents. This discrepancy required homes to scale up care provision, hire geriatric expertise, and absorb higher costs—demands that proved labour-intensive and were not always feasible. Language barriers and unexpectedly high care needs were among the most frequently cited reasons for discontinuing the recruitment of clients from Germany.

4.5. Links Between the Long-Term Care Sector and Other Business Sectors

For many care homes and intermediary agencies, catering to foreign seniors is just one strand of a broader business portfolio. Across all four countries, we encountered entrepreneurs active not only in long-term care but also in entirely unrelated sectors—waste management, technology, agriculture, and car trading among them. While such diversification into unrelated fields was the exception, links with tourism, construction, and real estate development were a consistent pattern across all four countries.

The link to tourism is particularly visible in the Polish regions of Lower Silesia and West Pomerania, the "spa triangle" of the Czech Republic, and the area around Lake Balaton in Hungary—all regions with long-standing tourism traditions. Care homes in these areas advertise beautiful landscapes and tourist amenities, and highlight convenient highway connections or nearby airports. We also encountered numerous care homes that had previously operated as hotels or bed-and-breakfast establishments. In regions with short tourist seasons, entrepreneurs saw senior care provision as a way to reduce dependence on seasonal income and establish a steadier revenue stream. Yet converting a hotel into a care home is far from straightforward: Many facilities listed as care homes on platforms had not yet recruited any foreign senior clients. This reinforces our argument that catering for German-speaking seniors is part of a broader business strategy, rather than a systematic development within local care regimes.

We also met several care entrepreneurs who were active in either the construction business themselves or had close family or business relationships with people in this industry. Others came from project management, consulting, or sales and marketing and seemed to regard developing a care home and hosting seniors as an alternative property investment (cf. Horton, 2021), or simply a profitable utilisation of existing buildings, as we learned in Slovakia and Poland. As one Slovakian owner stated: "If you want to reap the benefits from a building in the town, this is the way." In Poland, Hungary, and the Czech Republic, we came across projects

involving plans to build assisted living apartments for foreign seniors and thereby combine long-term care services with an investment scheme where (future) clients, but also relatives or other individuals, can invest in the construction of those buildings.

4.6. Interlinked (Care and Labour) Mobilities and Regional Histories

The establishment of private for-profit care homes and the recruitment of clients from across borders is linked in various ways to labour migration, transnational ways of being and belonging (Levitt & Glick-Schiller, 2004), and transnational ways of organising social protection (Bruzelius & Shutes, 2022), although these links played out differently in the four countries.

The link with care migration was particularly strong in Poland (Krzyżowski et al., 2017; Sapieha, 2026b) and, to a lesser extent, in the Czech Republic and Hungary. In all three countries, several employees had previously worked as live-in care workers or in health and nursing institutions in Germany and Austria before returning home. Although most did not hold formal nursing diplomas, they were sought after for their work experience, language skills (however limited), and "familiarity" with German seniors and "their ways." In one Czech case, a worker alternated between several weeks of live-in care in Germany and shifts in a care home for Germans at home. At the same time, as Jelínek shows (2025a, 2026), Czech care homes often lose workers whose German is "too good" to jobs in Germany, attracted by proximity to the border and higher wages.

Migration experience was also common among care home managers and owners. In the Czech Republic, we met a care home owner who had migrated to Germany in the 1990s to work in construction and later returned to convert his family house into a care home. In Poland, one founder had herself worked as an intensive care nurse in Germany before returning to establish a home there.

Given the general shortage of care workers across all four countries, care homes also relied on migrant labour to fill staffing gaps. In the Czech Republic and Poland, this drew particularly on workers from Ukraine and Moldova. Following the Russian invasion of Ukraine, the number of Ukrainian women employed in Polish homes increased significantly during our final fieldwork phase. These patterns show that care outsourcing is embedded in care chains identified by research on live-in care arrangements in Europe (Aulenbacher et al., 2024), forming part of the complex and unequal care mobilities within Europe (Bruzelius & Shutes, 2022; Ezzeddine & Krause, 2022).

Linkages with labour migration and live-in care migration were also evident among intermediary agents (Prieler, 2024). One notable example is a large Polish labour recruitment agency whose core business was recruiting live-in care workers from CEE countries for families in Germany and Austria; as a small sideline, it began connecting German families with care homes in Poland, becoming a pioneer in organising care relocation (Sapieha, 2026b). Agencies focused solely on care relocation were rare and, where they existed, tended to be very small—often consisting of individual brokers with transnational backgrounds themselves. Some were citizens of German-speaking countries who had settled in CEE countries, in some cases as retirement migrants; others were CEE citizens who had lived in Germany for a period or studied German at university, and who leveraged their language skills to act as intermediaries between families and care providers.

Regional transnational ways of being and belonging also shaped the lives of the residents. A care home complex in Poland illustrates this well. Located in a region with limited institutional care provision but a long history of transnational migration to Germany, the owner quickly filled a first home with Polish residents whose children lived abroad (and so could pay for the care). Using EU funds, she then established a second home targeting German-speaking seniors specifically. Of the approximately 60 residents, only two had no connection to Germany; all others had either lived there themselves and were funding their care from German pensions and insurance, had children or grandchildren living and working in Germany, or came from families belonging to the region's German minority. Among the German speakers, only a few had relocated solely for care purposes and spoke no Polish—all others had Polish-German backgrounds, though these were newly accentuated by the presence of the monolingual German-speaking residents (Jelínek & Krause, 2026).

Similar patterns emerged in Hungary, where residents in private care homes are often the parents of labour migrants who earn enough abroad to fund their parents' care back home, or are themselves return migrants who, after working lives spent in Germany, have accumulated pension or care insurance entitlements there and can therefore afford private care.

Migration histories among residents could be remarkably complex. In Poland, we met two men who illustrated this well: One had migrated as a so-called guest worker from Italy to Germany in his youth, another from Turkey. Both had stayed on, started families, and grown old in Germany. Their children, facing difficulties in organising affordable care, eventually moved them to Polish care homes, where they were treated as "German" seniors, despite both having retained little of their once rudimentary German.

As these examples make clear, the category of "German" is far from straightforward. One of the project's major findings is that the group we set out to research—German-speaking older adults receiving institutional care in the CEE region—is far from homogeneous. We began from media narratives suggesting that elderly German-speakers move directly from Germany or Switzerland, with no prior connection to the receiving country and purely for financial reasons, in order to access affordable yet high-quality care. In practice, these "parachuted seniors" constituted only a fraction of our participants. In Hungary in particular, we encountered many German speakers who had previously lived in the country. They had first spent their holidays in the region as children or as adults ("previous vacationers"), while others relocated as retirees and spent months or even years getting to know the local context before deciding to seek care there ("previous retirement migrants"; Prieler et al., 2026).

Another subgroup consisted of older persons (mentioned above) who had left their CEE home countries in earlier life to work in Germany or Switzerland, and had then returned post-retirement or upon developing care needs—what we call "returnees." Among these returnees, multilingualism and multiple citizenships were common, and so was having a pension and/or care-related entitlements from different countries. Some had not worked in German-speaking countries themselves but had children who did, and spent time abroad through them. This group was particularly visible in Poland in an area (Upper Silesia) shaped by transnational families (Palenga-Möllenbeck, 2014). Here, returnees also included members of German-speaking minorities and those who had experienced changing state affiliations in their biographies ("ethnic Germans"). They belonged to families from villages and towns which had been under Polish, Prussian, and German rule across the 20th century (Jelínek & Krause, 2026), and this background enabled a number to migrate to Germany

even before the fall of the Iron Curtain as "Spätaussiedler"—a legal status granted to those able to prove German descent, which applied to many Upper Silesians.

4.7. Historical Entanglements of German-Speaking Populations

The example of "Spätaussiedler" points to the complex histories of the regions in relation to German-speaking populations. In Poland, care homes in the historical regions of Pomerania and Upper Silesia can draw on workers and clients from transnational families with histories and links to both Poland and Germany (Krzyżowski et al., 2017), due to these regions' histories of shifting borders. In the Czech Republic, the historical dynamics did not involve shifting borders but population movements, notably in the former Sudetenland. All care homes serving German-speaking clientele are located in the former Sudetenland, which before the Second World War was inhabited primarily by German-speaking minorities who were expelled after the war, due to their mobilisation supporting the German Nazi regime and occupation. The German clientele in these homes were not returning Sudeten Germans. Yet the former Sudetenland region's complex history still resurfaces indirectly in its current socio-economic positioning (Jelínek, 2025b, 2026). The area never regained its pre-Second World War population density, remained relatively underdeveloped, and gradually became an outsourcing zone to which so-called Czech "problem populations" were relocated, including ethnic minorities and people with mental or health disabilities. One care home serving German-speaking clients, for example, was established in a former institution for people with mental disabilities. The closure of many factories has also left behind a pool of low-skilled workers who can be employed in care homes for comparatively low wages (Jelínek, 2025a, pp. 4–9, 2025c). With the opening of borders, new infrastructures have been developed to attract German visitors who frequently cross the border for petrol stations, casinos, brothels, dental clinics, beauty salons, and markets offering low-priced cigarettes, alcohol, and clothing (Lewicki & Probst, 2026). Care homes have thus become just one more service in a region shaped by cross-border mobility.

In all four countries, the continued presence of German language skills among local populations is actively leveraged in care relocation, alongside the advantage of proximity to the border. Care entrepreneurs in parts of Hungary, for instance, invoke the centuries-long presence of the "Donauschwaben"—German-speaking settlers invited by the Habsburg monarchy to repopulate territories along the Danube after the retreat of the Ottoman Empire—to explain why their region appeals to German-speaking seniors. In Silesia, Polish care managers rely on local German-speaking residents to translate for incoming German clients (Jelínek & Krause, 2026; Schurian-Dąbrowska & Krause, 2023). The distinctiveness of the regions where care homes cluster thus emerges from the interplay of historical trajectories and more recent investments, which together shape their attractiveness for cross-border care provision.

5. Conclusion

Our study confirms previous findings that the number of German-speaking seniors relocating for care to CEE countries is relatively small. It could therefore be argued that the phenomenon of care outsourcing within Europe does not deserve much attention, because it is neither solving the care shortages in German-speaking countries nor affecting greatly the host countries' care resources. However, we argue that care outsourcing is an interesting case to consider, since it is emblematic of the privatisation and marketisation of care in Europe and also shows how inequalities are written into transnational European welfare provision.

As we have shown in this article, the overarching tendencies towards the marketisation and privatisation of care across Europe, together with country-specific trends, show that the emergence of private care homes that (also) cater for German clients is shaped not only by shortages within the German long-term care regime but also by developments within CEE care landscapes and regimes towards exclusive marketisation. Furthermore, it is shaped by historical and regional dynamics such as past and present transnational migration patterns, interlinked with shifting state affiliations and populations. The emergence of private care homes catering to German clients is furthermore shaped by entrepreneurs' interlinkages with other business activities, who see the care business as one of several business opportunities. Within this picture, care outsourcing seems to be a side effect of marketisation.

The category "German" proved far more diverse than expected. Our initial online search focused on care homes advertising in German or on German-language platforms, assuming this signalled an interest in German clients. However, it became clear early in the research that the notion of Germanness needed to be unpacked, as its meaning varies both across countries and within regions. Many care homes are located in (former) border regions, where clients may belong to German-speaking minorities or have lived through shifting state borders. Some seniors are former local residents who acquired other citizenships during their migration trajectories and later chose to return for old age. Others worked in Germany for many years and therefore receive German pensions or care insurance benefits. Any inquiry into nationality, ethnicity, or language must therefore take this layered complexity into account.

In foregrounding these complexities, we argue for a shift away from a Western European-centric research logic in which CEE countries figure only as suppliers of cheap labour or as socio-economically deprived areas warehousing "problem populations"—a logic that reproduces categorisations of "the East" as a "reservoir of cheap labour" and land (Lewicki, 2023, p. 1482). Instead, we call for an approach that takes seriously the local histories of CEE care landscapes, moving beyond the care needs of wealthier Western countries that have so far dominated the literature.

Building on the work by Lewicki and Probst (2026), Palenga-Möllenbeck (2014, 2022), Safuta (2018), and others, we have taken initial steps in this direction by attending to local care landscapes and historically interlinked mobilities. In doing so, we aim to counter a double marginality: first, the well-documented neglect of care work; and second, the marginalisation of the places where it is conducted—CEE—within the unequal power geometry (Lewicki, 2023, p. 1483; Massey, 1993) of Europe. This power geometry risks being reproduced when the countries that export labour—and, in the case of care outsourcing, the countries that receive people with care needs—are afforded less analytical attention.

Thinking from the region furthermore brings into sight how regional landscapes of care provisioning are shaped by past and present mobilities, processes that are barely captured by dominant methodological nationalism in social policy research as forcefully argued by Bruzelius and Shutes (2022) and Lewicki and Probst (2026). These mobilities are linked to past and present economic inequalities and the wider history of the region, including conflicts and shifting state borders. As a result, some populations, for example from Polish Silesia, had privileged mobility rights due to citizenship rights even before EU accession. Related entitlements (e.g., pensions, care insurance) arising from these past mobilities can then be reinvested into the region's care landscape in various forms by entrepreneurs, care workers, clients, and transnational families. The phenomenon of care relocation therefore shows the relevance of not taking bounded nation

states as units of analysis when thinking about care provisioning and marketisation of care. It also requires bringing actors beyond the family and the state into the analysis of transnational care arrangements, including local entrepreneurs.

Care relocation is a reverse movement to the much-studied migration of care workers: It sends ageing bodies abroad rather than receiving younger ones to perform care work at home. It therefore points to the need to think about social protection, social policy, and the marketisation of care regimes transnationally, multidirectionally, and across multiple scales, including temporal scales of the past and the present (Bruzelius & Shutes, 2022). Within this frame, a picture emerges in which historically produced inequalities are not incidental but constitutive—shaping the transnational connections that structure CEE and the care solutions that older adults and their families within Europe pursue.

Acknowledgments

We thank the care home owners, managers, staff, and residents for their hospitality and patience. Special thanks to the CareOrg consortium for constructive comments, in particular to Noémi Katona, Dóra Gábriel, Maroš Matiaško, and to two anonymous reviewers.

Funding

We gratefully acknowledge funding from the Amsterdam Centre for European Studies, the Research Group Health Care and the Body (University of Amsterdam), ERC Starting Grant No. 949200, and the Volkswagen Foundation project CareOrg. Open access publication was made possible through the institutional agreement between the University of Amsterdam and Cogitatio Press.

Conflict of Interests

In this article, editorial decisions were undertaken by Ulf R. Hedetoft (University of Copenhagen).

Data Availability

The ethnographic data on which this study is based are stored on secure data servers at the University of Amsterdam. They are confidential and cannot be shared in accordance with research ethics commitments made to participants.

LLMs Disclosure

Claude Sonnet 4.6 (Anthropic), run in a secure, university-owned environment, was used only for language editing; it did not generate or modify the substantive content of this manuscript.

References

Allen, J., & Cochrane, A. (2007). Beyond the territorial fix: Regional assemblages, politics and power. *Regional Studies*, *41*(9), 1161–1175. https://doi.org/10.1080/00343400701543348

Aulenbacher, B., Décieux, F., & Riegraf, B. (2018). The economic shift and beyond: Care as a contested terrain in contemporary capitalism. In B. Aulenbacher, H. Lutz, & B. Riegraf (Eds.), *Global sociology of care and care work* (pp. 517–530). Sage.

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Ballestero, A., & Ross Winthereik, B. (2021). Introduction: Analysis as experimental practice. In A. Ballestero

& B. Ross Winthereik (Eds.), *Experimenting with ethnography: A companion to analysis* (pp. 1–12). Duke University Press.

Bally-Zenger, C., Eckenwiler, L., & Wild, V. (2017). "Alt werden im Paradies"—Die ethischen Aspekte der Migration von pflegebedürftigen Menschen. *Ethik in der Medizin*, *29*, 133–148. https://doi.org/10.1007/s00481-017-0438-8

Bender, D., Hollstein, T., & Schweppe, C. (2018). International retirement migration revisited: From amenity seeking to precarity migration? *Transnational Social Review*, *8*(1), 98–102. https://doi.org/10.1080/21931674.2018.1429080

Bruzelius, C., & Shutes, I. (2022). Towards an understanding of mobility in social policy research. *Global Social Policy*, *22*(3), 503–520.

Chatzidakis, A., Eckhardt, G., & Husemann, K. (2025). The cumulative effects of marketized care. *Journal of Consumer Research*, *51*(5), 959–981.

Czepulis-Rutkowska, Z. (2017). Long-term care for the elderly in Poland. In B. Greve (Ed.), *Long-term care for the elderly in Europe: Development and prospects* (pp. 38–58). Routledge.

Da Roit, B., Le Bihan, B., & Österle, A. (2016). Cash-for-care benefits. In C. Gori, J.-L. Fernández, & R. Wittenberg (Eds.), *Long-term care reforms in OECD countries* (pp. 143–166). Policy Press.

Dahl, H. M. (2017). *Struggles in (elderly) care: A feminist view*. Palgrave Macmillan.

de Vries, B. (2021). Granny-export? The morality of sending people to care homes abroad. *Bioethical Inquiry*, *18*, 455–464. https://doi.org/10.1007/s11673-021-10118-y

Dowling, E. (2022). *The care crisis: What caused it and how can we end it?* Verso.

Dudová, R. (2018). Doing gender and age: The case of informal elderly care in the Czech Republic. *International Journal of Ageing and Later Life*, *12*(1), 42–73. https://doi.org/10.3384/ijal.1652-8670.17325

Dwyer, P. (2001). Retired EU migrants, healthcare rights and European social citizenship. *Journal of Social Welfare and Family Law*, *23*(3), 311–327. https://doi.org/10.1080/01418030126399

Ezzeddine, P., & Krause, K. (2022). Profitable bodies and care mobilities in Central and Eastern Europe. *Global Dialogue*, *12*(3), 41–42.

Farris, S. R., & Marchetti, S. (2017). From the commodification to the corporatization of care: European perspectives and debates. *Social Politics: International Studies in Gender, State & Society*, *24*(2), 109–131. https://doi.org/10.1093/sp/jxx003

Gábriel, D. (2022). Hungarian migrant care workers between local and cross-border care loops. In L. Näre & L. W. Isaksen (Eds.), *Care loops and mobilities in Nordic, Central, and Eastern European welfare states* (pp. 63–83). Springer.

Gál, R. I. (2017). Long-term care for the elderly in Hungary. In B. Greve (Ed.), *Long-term care for the elderly in Europe: Development and prospects* (pp. 8–22). Routledge.

Großmann, S., & Schweppe, C. (2020). Just like in Germany, only better? Old-age care facilities in Poland for people from Germany and the question of legitimacy. *Ageing & Society*, *40*(4), 823–841. https://doi.org/10.1017/S0144686X18001290

Gyarmati, A. (2019). *Ageing and care for the elderly in Hungary: General survey and problems*. Friedrich Ebert Foundation.

Horn, V., & Schweppe, C. (2017). Transnational aging: Toward a transnational perspective in old age research. *European Journal of Ageing*, *14*, 335–339. https://doi.org/10.1007/s10433-017-0446-z

Horn, V., Schweppe, C., Bender, D., & Hollstein, T. (2016). Moving (for) elder care abroad: The fragile promises of old-age care facilities for elderly Germans in Thailand. In V. Horn & C. Schweppe (Eds.), *Transnational aging: Current insights and future challenges* (pp. 163–177). Routledge.

Horton, A. (2021). Liquid home? Financialisation of the built environment in the UK's "hotel-style" care homes. *Transactions of the Institute of British Geographers*, *46*(1), 179–192.

Jelínek, M. (2025a). Shared language as a scarce resource: Organizing communication in care homes with foreign clientele. *Human Organization*, *84*(3), 304–315. https://doi.org/10.1080/00187259.2025.2505868

Jelínek, M. (2025b). *Why here? Contextualizing the care relocation of German-speaking seniors to the Czech borderlands* [Unpublished PhD dissertation]. Amsterdam Institute for Social Science Research.

Jelínek, M. (2026). Mobilizing and balancing differences: Care relocation as the work of transnational acting. *Global Networks*, *26*(1), Article e70041. https://doi.org/10.1111/glob.70041

Jelínek, M., & Krause, K. (2026). How care relocation (re)articulates German histories of Central and Eastern Europe. *HAU: Journal of Ethnographic Theory*, *16*(2).

Johnston, C., & Pratt, G. (2022). Anticipating a crisis: Creating a market for transnational dementia care in Thailand. *Annals of the American Association of Geographers*, *112*(7), 2064–2079. https://doi.org/10.1080/24694452.2022.2041389

Káčerová, M., Ondoš, S., & Miláčková, M. (2021). Regionálne nerovnosti v zdravotnej a sociálnej starostlivosti na Slovensku. *Geographia Cassoviensis*, *15*(2), 135–149.

Katona, N., & Zacharenko, E. (2021). *The dependency on East-to-West care labour migration in the EU: Addressing inequalities and exploitation*. Friedrich Ebert Foundation.

Kindler, M. (2008). Risk and risk strategies in migration: Ukrainian domestic workers in Poland. In H. Lutz (Ed.), *Migration and domestic work: A European perspective on a global theme* (pp. 145–160). Ashgate.

KPMG. (2021). *Study on the long-term care supply and market in EU member states: Final report*. Publications Office of the European Union.

Krzyżowski, Ł., Slany, K., & Ślusarczyk, M. (2017). Care issues in transnational families: A Polish research review. *Polish Sociological Review*, *199*(3), 367–385.

Levitt, P., & Glick-Schiller, N. (2004). Conceptualizing simultaneity: A transnational social field perspective on society. *International Migration Review*, *38*(3), 1002–1039. https://doi.org/10.1111/j.1747-7379.2004.tb00227.x

Lewicki, A. (2023). East–west inequalities and the ambiguous racialisation of 'Eastern Europeans.' *Journal of Ethnic and Migration Studies*, *49*(6), 1481–1499. https://doi.org/10.1080/1369183X.2022.2154910

Lewicki, A., & Probst, U. (2026). Sex, care and the working body: Ambiguities of the gendered racialisation as 'Eastern European.' *Journal of Ethnic and Migration Studies*, *52*(1) 41–64. https://doi.org/10.1080/1369183X.2025.2462779

Massey, D. (1993). Power-geometry and a progressive sense of place. In J. Bird, B. Curtis, T. Putnam, G. Robertson, & L. Tickner (Eds.), *Mapping the futures: Local cultures, global change* (pp. 59–69). Routledge.

Michel, S., & Peng, I. (Eds.). (2017). *Gender, migration, and the work of care: A multi-scalar approach to the Pacific Rim*. Palgrave Macmillan.

Milligan, C., & Wiles, J. (2010). Landscapes of care. *Progress in Human Geography*, *34*(6), 736–754. https://doi.org/10.1177/0309132510364556

Ormond, M., & Toyota, M. (2016). Confronting economic precariousness through international retirement migration: Japan's old age refugees and Germany's "exported grannies." In V. Horn & C. Schweppe (Eds.), *Transnational aging: Current insights and future challenges* (pp. 134–145). Routledge.

Palenga-Möllenbeck, E. (2014). *Pendelmigration aus Oberschlesien: Lebensgeschichten in einer transnationalen Region Europas*. transcript.

Palenga-Möllenbeck, E. (2022). Making migrants' input invisible: Intersections of privilege and otherness from a multilevel perspective. *Social Inclusion*, *10*(1), 184–193. https://doi.org/10.17645/si.v10i1.4789

Peng, I. (2024). Brokering care migration: A new element in the transnational worker supply chain. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 295–310). Sage.

Pratt, G., & Johnston, C. (2022). Dementia care for Europeans in Thailand: A geography of futures. *American Behavioral Scientist*, *66*(14), 1880–1895. https://doi.org/10.1177/00027642221075263

Prieler, V. (2024). Emotional support, matchmaking, and administrative services as care work: Intermediaries' role in relocating seniors to care homes abroad. In R. Atzmüller, K. Binner, F. Décieux, R. Deindl, J. Grubner, & K. Kreissl (Eds.), *Gesellschaft in Transformation: Sorge, Kämpfe und Kapitalismus* (pp. 89–98). Beltz Juventa.

Prieler, V., Krause, K., & Horváth, H. (2026). Moving to Hungary in later life: (In)dependence and transnational inequalities in assisted living abroad. *Berliner Journal für Soziologie*, *35*(3), 533–547. https://doi.org/10.1007/s11609-026-00592-9

Safuta, A. (2018). Fifty shades of white: Eastern Europeans' 'peripheral whiteness' in the context of domestic services provided by migrant women. *Tijdschrift voor Genderstudies*, *21*(3), 217–231. https://doi.org/10.5117/TVGN2018.3.002.SAFU

Safuta, A. (2021). When policy entrepreneurs fail: Explaining the failure of long-term care reforms in Poland. *Social Policy & Administration*, *55*(6), 1098–1111. https://doi.org/10.1111/spol.12714

Sapieha, M. (2026a). *Manor house, state farm, and a care home: Mobilising phantoms and ghosts to study history in care*. Manuscript submitted for publication.

Sapieha, M. (2026b). *The entrepreneurial turn in the marketisation of care in Poland*. Manuscript submitted for publication.

Schurian-Dąbrowska, L. (2019). *German seniors' ways of relating in a Polish care home. A study on the messiness of everyday life* [Unpublished master's thesis]. University of Amsterdam.

Schurian-Dąbrowska, L., & Krause, K. (2023). Researching words without speaking them: Language as care practice in multi-lingual care environments in Poland. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, *42*(8), 815–827. https://doi.org/10.1080/01459740.2023.2223998

Schweppe, C. (Ed.). (2022). *Retirement migration to the Global South: Global inequalities and entanglements*. Springer.

Schwiter, K., Brütsch, J., & Pratt, G. (2020). Sending granny to Chiang Mai: Debating global outsourcing of care for the elderly. *Global Networks*, *20*(1), 106–125. https://doi.org/10.1111/glob.12231

Sciortino, G. (2004). Between phantoms and necessary evils: Some critical points in the study of irregular migrations to Western Europe. *Beiträge*, *24*, 17–43. https://osnadocs.ub.uni-osnabrueck.de/handle/urn:nbn:de:gbv:700-201001304820

Social Protection Committee. (2021). *Long-term care report: Trends, challenges and opportunities in an ageing society* (Vol. 2). Publications Office of the European Union.

Souralová, A., & Šlesingerová, E. (2017). Post-socialist eldercare in the Czech Republic: Institutions, families, and the market. In K. Christensen & D. Pilling (Eds.), *The Routledge handbook of social care work around the world* (pp. 159–170). Routledge.

Spasova, S., Baeten, R., Coster, S., Ghailani, D., Peña-Casas, R., & Vanhercke, B. (2018). *Challenges in long-term care in Europe: A study of national policies*. European Commission, European Social Policy Network.

Szüdi, G., Kováčová, J., & Konečný, S. (2016). Transformation of social care services for elderly in Slovakia. *Journal of Social Service Research*, *42*(2), 199–217. https://doi.org/10.1080/01488376.2015.1129016

Theobald, H. (2012). Combining welfare mix and new public management: The case of long-term care insurance in Germany. *International Journal of Social Welfare*, *21*, 61–74.

Uhde, Z., & Ezzeddine, P. (2019). Transnational migration: Borders, gender and global justice challenges. *Gender a výzkum/Gender and Research*, *20*(1), 3–17.

van Horen, F., Deneva-Faje, N., Dutchak, O., Ezzeddine, P., Fedyuk, O., Földes, I., Fiebig-Spindler, R., Gábriel, D., Hărăguş, M., Hernandez, S., Katona, N., Krause, K., Matiaško, M., Oksiutovych, A., Palenga-Möllenbeck, E., & Ursu, D. (2026). *The absence of the state in care for older people in Central and Eastern Europe: A comparative analysis of priorities and silences in policy and political discourse*. Manuscript submitted for publication.

Williams, F. (2018). Care: Intersections of scales, inequalities and crises. In B. Aulenbacher, H. Lutz, & B. Riegraf (Eds.), *Global sociology of care and care work* (pp. 547–561). Sage.

Wrotek, M., & Kalbarczyk, M. (2025). Efficiency of the long-term care sector in Poland based on an Activities of Daily Living evaluation. *Social Policy and Society*, *25*(1), 137–156.

About the Authors



Kristine Krause (PhD) is a professor of anthropology at the University of Amsterdam. She is the PI of the ERC-funded project Relocating Care Within Europe (ReloCare; https://www.relocatingcare.org) and partner in the Volkswagen foundation-funded project CareOrg (https://careorg.eu). Her research interests include history in transnational care, intimate outsourcing, citizenship, and political subjectivities.



Veronika Prieler (PhD) has worked as postdoctoral researcher within the project Relocating Care within Europe at the Amsterdam Institute for Social Science Research. She holds a PhD in sociology from the Johannes Kepler University Linz, where she was part of the research project Decent Care Work? Transnational Home Care Arrangements.



Hanna Horváth (MSc) is a medical anthropologist with an interdisciplinary background in the social sciences. She works as junior researcher in the research project Relocating Care within Europe and as research assistant within the Amsterdam Institute of Social Science Research. Her research interests include reproductive health and feminist theories.



Matouš Jelínek (PhD) is an anthropologist and social worker and received his PhD in anthropology from the University of Amsterdam within the project Relocating Care within Europe. He holds master's degrees from Masaryk University and the University of Bergen. His research investigates how history and categories of difference shape care and social services.



Mariusz Sapieha is a PhD researcher at the Anthropology Department at the University of Amsterdam working on topics of care, history, and entrepreneurship. He is a part of the ERC project Relocating Care within Europe. He received his previous higher education at the University of Warsaw and the University of Amsterdam.



Zuzana Sekeráková Búriková (PhD) is an anthropologist and associate senior researcher at the Institute for Sociology, Slovak Academy of Sciences. Her work focuses on care, paid domestic workers, care ethics, and home, with current research focusing on how digital technologies shape care relationships and the intersections of care and surveillance.



Petra Ezzeddine (PhD) is an assistant professor at the Department of Social and Cultural Anthropology, Charles University Prague. Her research focuses on migration, transnational care practices, globalisation of care, and ageing in migration. She currently leads the Czech team of the Volkswagen foundation-funded project CareOrg (https://careorg.eu).



Luise Schurian-Dąbrowska (MSc) holds a master's in medical anthropology and sociology from the University of Amsterdam and works as project manager at the Swiss Academy for Development in Switzerland. She conducted her master's research on the outsourcing of care from Germany to Poland.

Social Inclusion
2026 • Volume 14 • Article 12324
https://doi.org/10.17645/si.12324

cogitatio

ARTICLE

Open Access Journal

Imagining Care: Transnational Inequality and Older Age Prospects for Ukrainian Caregivers in Italy

Oksana Dutchak [1], Olena Fedyuk [2], and Anna Oksiutovych [1]

[1] CareOrg, Ukraine
[2] CareOrg, Germany

Correspondence: Oksana Dutchak (ok.dutchak@gmail.com)

Submitted: 3 March 2026 **Accepted:** 25 May 2026 **Published:** 22 July 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

This article explores how Ukrainian migrant care workers in Italy imagine their own future care in older age while sustaining aging societies through paid work. The analysis is conceptually grounded in the critique of gendered transnational care chains. We ask how women working in senior care define sustainable care for themselves, how these visions relate to their professional trajectories and transnational family experiences, and how they negotiate dignity and security in later life. Empirically, the study draws on 16 biographical interviews with Ukrainian women aged between 37 and 72, conducted in Italy in 2024. We argue that a prolonged engagement in senior care produces both a critical awareness of care inequalities and volatile prospects for their own old age. This results in individualized strategies alongside emerging collective imaginaries of self-organized care.

Keywords

care inequality; migration; professionalization; senior care; transnational care chains

1. Introduction

Since the post-Soviet opening of Ukraine's borders in 1993, Italy has consistently ranked among the top destinations for Ukrainian migrants, alongside Russia, Poland, and the Czech Republic (Vakhitova & Fihel, 2020). Yet Italy stands apart in demographic terms: For three decades, more than 80% of Ukrainian migrants there have been women, most of them over 50 (Istituto Nazionale di Statistica, 2022, p. 4; Marchetti & Venturini, 2013, p.114; Tyldum, 2014, p. 59; Vianello, 2016, p. 166). This feminized and aging migration

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

stream is not incidental, and it stems from a particular labor demand in the receiving country. As Franca van Hooren conceptualizes it, the Italian welfare regime has institutionalized a "migrant in the family" model (van Hooren, 2012), outsourcing care deficits to live-in migrant women. In this arrangement, Ukrainian migrant women in Italy became intimately embedded in households while remaining structurally marginal to formal welfare provision.

Such a demographic configuration produces what might be termed an aging dilemma. Women who sustain aging societies through intimate labor are themselves aging within migration. Their migration and professional trajectories, transnational family ties, and often precarious legal positions complicate their future security, and this raises uneasy questions about their own prospects in old age. Russia's invasion of Ukraine and the resulting complex threats and instabilities have become further factors jeopardizing the futures of Ukrainians, Ukrainian society, and care for older people in the country (Dutchak, 2024; Strelnyk, 2026; see also Dutchak et al., 2026). Our article explores imaginaries linked to care options in older age present among current care workers and asks: How do migrant care workers imagine care solutions for themselves? How are their care imaginaries related to their experiences as migrant workers in the Italian senior-care sector? We argue that, while the very model that secures their employment offers no obvious template for their own old age, women's imaginaries about the future are largely informed by their present-day experiences of inequalities, precarity, and uncertainty, rather than being oriented toward specific practical steps linked to securing the future.

While the issue of care for migrants in older age goes mostly unrepresented, their direct embeddedness in transnational senior-care chains creates an important vantage point to better understand the deep systemic inequalities that not only channel migration, and shape working and living conditions, but also structure what follows: migrants' own aging. Furthermore, working in senior care cultivates skills, dispositions, and professional trajectories that inform and influence migrants' understandings of what care is, how it can be organized, and how it ought to be delivered (Ayalon & Rapolienė, 2022). Attending to care migrants' imaginaries and future-oriented reflections allows structural inequalities within care systems to be traced through lived experience, because women project lessons from paid care and migratory life onto their own anticipated old age.

2. Methodology

During fieldwork across Italy in February and March 2024, Anna Oksiutovych collected 16 semistructured biographical interviews with Ukrainian current and former workers taking care of older people. She recruited the interviewees during the fieldwork, engaging researchers' informal networks, diasporic actors (church networks and cultural initiatives), field-based recruitment, and a snowball approach. The only important parameter for this research was experience as a Ukrainian migrant working in care for older people in Italy, and so no other criteria were used to guide selection.

The women were often approached about the research interview in public places or during gatherings: for example, in a parking space near a supermarket, in a park where they would usually meet up on their day off, after church mass, or at a tea party they organize. To build trust during these meetings, the researcher informed them not only about the research but also about herself and her background as a Ukrainian with refugee status. Eventually, some of the women agreed to talk with her privately when they had time. The question of time was not a simple one because many of these women worked intensively and might have only one day, half

a day, or even just a few hours a week off. For this reason, the researcher had to do some interviews in two rounds because there was not enough time to discuss everything at once.

All interviewees were women aged between 37 and 72 years. The age distribution was as follows: Three women were aged between 37 and 40, six between 41 and 60, and seven were over 60 years old. Twelve participants migrated to Italy between 1999 and 2010, while four migrated after 2010. This diverse range of ages and the generally early migration among the participants matches a well-established Ukrainian-Italian migration pattern that has evolved over the past decades (Fedyuk, 2012; Mudrak, 2011; Odynets, 2021; Solari, 2017; Vianello, 2016). While most of the interviewees started their labor migration as live-in senior carers, their further trajectories varied: Five were staying in live-in care at the time of research, four had switched to live-out care and worked on an hourly basis, one had moved to work in a public residential facility for seniors, five had left the senior care sector after experience with live-in arrangements, and one had left the sector after consecutive experiences of live-in and public residential care. All names have been changed to preserve anonymity.

The interviews were based on an open-ended and narrative interview guide that addressed four main topics related to care perceptions, arrangements, and imaginations: (a) the experiences and perceptions of professionalization in the care industry; (b) the comparative narrative about care for older people in Italy and in Ukraine; (c) their own (if existing) care arrangements for older relatives; and (d) their overall narrative about their future and care in their own older age. These were the four topics that became the basis for further thematic analysis through which we reconstructed how structural, personal, and professional dimensions condition women's opinions about different care arrangements, actual care arrangements in their families, the ideal-type groups of care migrants' future imaginaries, and the links between these actual and imagined care experiences.

To construct the part of the guide about the future and care, we repeatedly revised and adjusted the research questions and approach after the first interview. Almost immediately we encountered a barrier in women imagining their older age—one corroborated by existing research and explained by a number of causes, including ageism, people's perception of aging as physical and mental deterioration, and a series of socioeconomic difficulties associated with aging (Jones, 2011, pp. 19–20). Based on this, we switched to asking more specific questions about a person's future, which helps "to move people from the vastness of trying to imagine a whole future to the much more manageable task of imagining one particular aspect of it" (Jones, 2011, p. 23). By prioritizing the question of how they imagine care for themselves in older age, we brought the focus immediately to the question of care. This was an organic continuation of the previous questions about women's work experience; while formulating imaginaries for future care, women often broadened the focus to the future in general.

Such an adjustment did not allow us, however, to totally overcome the barrier of accessing imaginaries. Reflecting on this, we assume that the barrier has two components: There is a general problem of how to access something that "cannot be grasped directly" (Cantó-Milà & Seebach, 2024, p. 304), how "to explore the 'not known'" (Pink et al., 2020, p. 136), and the specific problem related to the embedded uncertainties of transnational care chains that have no clear care options for aging migrant care workers. To address the general problem of exploring the unknown, we asked speculative questions that tackle the imaginaries "rooted in existing ways of knowing" but also in "reconfiguring, adapting and crafting" (Pink et al., 2020,

p. 136). The specific problem related to care inequalities and difficulties for people to imagine their future care in the existing system became an integral component of the empirical material that we analyze further.

An ethnographic researcher completing fieldwork is always, to some extent, an active participant in the field. At the same time, we are conscious that when the fieldwork engages with "reconfiguring, adapting and crafting" imaginaries of the future, the ethnographic method not only investigates the "active and situated work of futuring" (Oomen et al., 2022, p. 248) but may also become a part of it: While speaking with the women, we encouraged them to seek and articulate imaginaries that some of them did not have clearly preformulated.

3. Literature Discussion: The Future of "Ageless" Migrants Within Care Inequalities

Discussions about the old-age prospects of migrants often revolve around the question of managing migrant flows (Bastia et al., 2022; Ciobanu et al., 2019; World Health Organization, 2018) and the related issue of staying or returning. From the perspective of receiving states, the political economy of migration rests on the assumption of the ageless, interchangeable worker—captured by John Berger and Jean Mohr in *A Seventh Man* (Berger & Mohr, 1989): "They are not born: they are not brought up: they do not age: they do not get tired: they do not die" (p. 64). This imaginary presumes eventual return, externalizing the social and fiscal costs of aging (Anderson, 2000). In practical terms, this expectation often translates into various state policies aiming, on the one hand, to facilitate migrants' return, and on the other, to retain those with "valuable" skills and knowledge. Thus, the countries of origin promote return migration as a strategy for harnessing acquired skills, knowledge, and "innovation," countering the perceived losses of a "brain drain" (Ayalon & Rapolienė, 2022; Cassarino, 2004; Lang, 2013).

In research, approaches to the issues of staying or returning vary from the neoclassical, focused on rational calculating agents (Dustmann, 1996; Martin & Radu, 2012), to those explaining migrants' choices through various structures (Hunter, 2018; Kristiansen et al., 2015; Kröger & Zechner, 2009), interpersonal ties and relations (Fedyuk, 2021; Kröger & Zechner, 2009; Lados & Hegedűs, 2016; Ryan, 2007), and their subjective emotions and psychological state (Baas, 2015; Tılıç-Rittersberger et al., 2011). This combination of the structural, relational, and personal aspects forms a complex picture in which some return to their home countries, others definitely stay, and yet others travel back and forth while possible, postponing the ultimate decision for later (Kristiansen et al., 2015; Lutz & Palenga-Möllenbeck, 2012; Odynets, 2021; Radziwinowiczówna et al., 2018). For many, the final return becomes a myth (Berger & Mohr, 1989; Fedyuk, 2025; Vianello, 2016) often representing the "ideology of return" (Brettell, 1979).

In focusing on structural conditions, access to healthcare, welfare, and social care are singled out both as factors linked to staying (Hunter, 2018; Kristiansen et al., 2015; Tılıç-Rittersberger et al., 2011) and returning (Kröger & Zechner, 2009) in older age. In this relation, migrants' access to senior care in hosting countries has been increasingly studied, including the barriers, policies, and possible improvements (Al-Hamad et al., 2025; Brandhorst et al., 2019; Carlsson & Pijpers, 2021; McGrath et al., 2022). Our case follows up on the existing research conclusion that migrants' access to care in a destination country is predetermined by the multiple inequalities within which the migration unfolds.

Most of the existing research on migrant aging does not single out the aging of care migrants as a separate focus. At the same time, while transnational care migration fills in the gaps in senior care provisioning in some countries—yet also creating "care drain" in others—their experiences become the concentrated manifestations of global care inequality as "an implicit aspect of transnational care giving" (Lutz, 2018, p. 583). From the latter perspective, the issues of transnational motherhood have been widely researched, including in the context of Ukrainian care migration (Fedyuk, 2012; Leifsen & Tymczuk, 2012; Lutz & Palenga-Möllenbeck, 2012; Marchetti & Venturini, 2013; Tyldum, 2014), though, as noted by some scholars, the issue of transnational care for migrants' aging parents is far less examined (Mudrak, 2011, pp. 55–57; Solari, 2017; World Health Organization, 2017, p. 52). The latter is also true in relation to senior care for aging migrant senior carers (Mudrak, 2011, pp. 55–57)—but this part of the puzzle is barely placed within the care-inequality approach.

Research suggests that living as migrants while providing paid senior care can reshape perceptions of aging and later-life care (Ayalon & Rapolienė, 2022), potentially positioning migrants as "agents of change" in their home societies (Ayalon, 2021, p. 2257). Our findings confirm that professional trajectories shape migrants' imaginaries of future care, but that this relationship is not linear. Structural care inequalities often constrain their ability to secure care for older relatives and imagine future forms of care for themselves. Our research centers on the imaginations of the workers as a route to focus on existing and perceived inequalities. At the same time, we maintain the perspective of the workers who are not passive objects in this situation but rather actively search for available solutions. These solutions are often, however, shaped by existing and perceived obstacles or by failures in the care landscape.

We therefore turn to the sociology and anthropology of the future to understand Ukrainian care migrants' imaginaries of their own old age and possible care. More specifically, we rely on a line of theorizing that "analytically engages with perceptions of the future" (Suckert, 2022, p. 396) as a way of "exploring and understanding social realities of the present" (p. 394). We acknowledge the overlapping meanings of various terms and the interwoven presence in daily life of such phenomena as expectations, aspirations, future imaginaries, narratives about the future, etc. (Bazzani, 2023; Bryant & Knight, 2019; Vignoli et al., 2020). In making a pragmatic choice, we employ the concept of future imaginaries as a broad phenomenon that "join[s] together elements of the present with some normative value orientations" (Vignoli et al., 2020, p. 36) and that encompasses "shared but not uniformly held assumptions, expectations, anticipations, fears, plans and hopes about what lies ahead" (Cantó-Milà & Seebach, 2024, p. 304). Being partially based on expectations and informing narratives of the future (Bazzani, 2023; Vignoli et al., 2020), future imaginaries are less constrained by actual reality than expectations and do not necessarily include actionable components integral to narratives of the future. Hence, future imaginaries are suited to exploring people's understanding of the possible and desirable without forcing them into an action-oriented exploration. This, we argue, allows us to simultaneously grasp people's perception of existing constraints but also their wishes and awareness regarding various care practices. They may have developed these through experience and professionalization, yet they may look practically out of reach under the current conditions.

We now turn to discuss the three main groups of migrants' care-related future imaginaries that we identified in our research. We give them operational names and analyze how these imaginaries relate to existing inequalities in transnational care chains, migrants' experiences of migration and professionalization, and their actual care arrangements.

4. A Familialistic Imaginary: "I Would Really Like to Be Around My Children"

Maria is over 60 years old and has spent almost a third of her life caring for senior people in Italy. Like many Ukrainian women, she started as an undocumented labor migrant, soon legalizing her status and continuing as a live-in carer for years, sometimes with a contract—and sometimes without. For the past couple of years, thanks to being able to save some money and improve her situation gradually, Maria has switched to live-out care. Imagining her aging, Maria describes a desirable scenario:

> I would really like to be around my children, near my daughter. And I hope that….I have already programmed them that way….I say, "Children, I have to live to be 95 years old. I have to celebrate my birthday, my anniversary—95 years old. And invite you all, have a nice dinner with you. Then say goodbye, go to bed, and never get up again." And I would really like it to be like that.

As the data show, this idea of aging around one's family and having them take care of you is a dominant one among older people in Ukrainian society, and it interlinks with the prevailing familialistic model of senior care (Strelnyk, 2026; see also Dutchak et al., 2026). Our research demonstrates that at least some Ukrainian care migrants replicate these dominant sociocultural norms and project them into their own future.

Despite the somewhat different sociodemographic characteristics and migration trajectories, there are important similarities between Maria's perception of care practices and that of some other research participants with familialistic imaginaries of the future. First and foremost, they emphasize the differences between the Ukrainian and Italian senior care cultures, both favoring the Ukrainian one. For example, Vita—another caregiver in our research—tells the story of familialistic care for her mother, now deceased. She reflects about the intensive involvement of her extended family, and she compares this to what she saw during her care work in Italy:

> Here, if you're old, you have a *badante* [carer]. And we have this family warmth, which I miss here….Here, when you're older, no one [will take care of you] anymore. Everyone lives their own life….I've rarely seen people in Italy who sacrifice their lives, their pleasures, for their parents.

Maria similarly stresses that Ukrainians and Italians have "different mentalities," through which she explains the different senior care arrangements in the two countries. Yet, while she depicts the Ukrainian familialistic model in her future imaginary, it is important to note that care arrangements in her own family diverge from it. Maria's sister cared for their mother while she and other siblings were already abroad, supporting her materially. With their father, this type of arrangement was not possible anymore, as the remaining sister lived farther from him, and so the siblings hired a relative to take care of the man.

Another similarity in care-related reflections, expressed by women sharing familialistic imaginaries of the future, is related to their perception of their job, experience, and skills. On the one hand, reflecting on the skills and knowledge she attained while working in senior care, Maria mentions many healthcare-related tasks she is able to do now: giving injections and drips, changing a catheter, controlling oxygen and medication. At the same time, after proudly stating that "I have truly developed professionally," Maria describes this professional growth in terms of psychological adaptability, patience, a kind attitude, and the building of trust and confidence:

> For this job, you need to have patience, desire, understanding why you came here….I have to present myself in a way so that [the client] trusts me, because I entered her house. She has to have that trust in me, to be confident. I had to really demonstrate that love, respect….We have to adapt to everyone. And I learned a lot from that.

In Vita's case, her emphasis on her personal attitude and the relations between carers, clients, and their family reaches a point where it wholly consumes her understanding of the profession: "In general, working as a *badante*—I can't call it a job. I tell many people, it's life. Because you live with a person 24 hours a day. This is how they are so dear to you." She continues, saying that the clients remind her of her grandmother. This helps her to build an emotional connection and, eventually, to care for them. The same emotional connection, however, made her quit the sector altogether, as she was not able to stand death anymore. Vita describes the last days of her client: "I had to hold her hand, because she was scared at that moment. And when she died, I just said that I couldn't take that loss anymore"—she emphasizes this once again—"because being a *badante*—this is not a job."

The motto "This is not a job" represents an opposite to perceiving oneself as a professional and a radical equation of care with family-like relations, even when it is paid. We encountered this narrative among several Ukrainian migrant carers in Italy, all working in live-in senior care (though not all live-in carers share it). For example, Zoya, who has worked in Italy for two decades, including 15 years with one family, caring for successive older relatives, repeated this phrase several times in her interview. In her account, the logic runs deep: She contrasts her work with her husband's work in a residential facility, saying he "knows how to care," while she does not. Recalling a client's decline, she explained that she feared she could no longer help enough and so the family would soon hire a *badante*—as if she were not one herself. Like Vita, she found the deterioration and death of those she had grown attached to emotionally difficult and was unable to build a professional distance or indifference.

5. An Institutional Imaginary: "*Struttura* Is Salvation"

Larysa's imaginary of her future care contrasts sharply with a familialist imaginary. The woman is 45 years old, and she was trained as a nurse in Ukraine but moved to Italy 17 years ago. There she first worked as a live-in senior carer for some years but later switched to working as a janitor in a *struttura*—a public residential care facility for senior people. After a while, she took courses that allowed her to work as a carer in the same facility. When asked about care for herself in older age, and if any would be needed, she says:

> After this *struttura* where I work, I'm looking at a *struttura* where I would go to live out my life. Yes. This, this is my first option. I don't want children to take care of me. It's very stressful, and it's very hard for the children. It's better for the children to live their own lives.

Larysa's care migration history is not quite typical for Ukrainians in Italy, because only a few Ukrainians were able to make the transition to work in residential care. Such a trajectory represents a bottleneck some of them pass through, usually after sequentially working in live-in and live-out care. Another woman with a similar trajectory, whom we talked to, recalls that when she started to work in a facility some years ago, she was not just the only Ukrainian, but the only foreign worker there, and that "everyone was looking at me like I was a monkey that had climbed down from a palm tree."

To become a carer working in residential care in Italy, a person has to go through a process of formal professionalization. This may, in turn, impact women's understanding of care as a profession. When speaking about the skills and knowledge she acquired while working in Italy, Larysa spoke about a number of training courses she took before and while working at the facility. Although a trained nurse in Ukraine, she highly values the new skills she learned in Italy, including technical and procedural knowledge, but also, for example, psychological approaches to older and dying people.

In Larysa's case, professionalization had a great impact on her attitudes to care. She enjoys sharing many details about how the different residential facilities work in different European countries, having learned this from other workers in her own workplace. Reflecting on such senior care arrangements, Larysa talks a lot about how older people in residential care facilities have the opportunity to be active for as long as their health allows, and to receive more intensive care when their health deteriorates significantly. She describes older people's leisure, visits by friends and relatives, and funerals and weddings she observed during a decade of work in the facility, and she stresses several times that "they continue living their own lives." This active life, from her perspective, combined with providing sufficient material conditions and autonomy to seniors, all form the most important things a *struttura* can give, and those are things she wishes for herself in older age.

Another significant part of Larysa's reflections on the benefits of institutional care is how a facility can shift the burden of care from one's children, who, she believes, should be able to continue living their lives. This element is present in her care-related future imaginary, but also in the story about her work experience. It becomes the most prominent when Larysa describes her training at a day-care facility for older people with Alzheimer's disease:

> I was so impressed, then, that I was shocked….In this *struttura*, so-called, they are here all day, and in the evening they are taken to their homes….Not all relatives can live with Alzheimer's. This *struttura*—it was salvation…the relatives are free. And these people are brought home. They have eaten, they are rested, clean because they were washed there, and have everything that is needed. That was such an experience for me!…It was a new world, I had never seen anything like that.

Besides the perception of care facilities as salvation for families, who can continue with their daily life while their seniors are properly taken care of, what stands out is Larysa's initial cultural shock and appreciation of the arrangement. Zoya, whom we mentioned in the previous section, also voiced this changing attitude to institutional care. During the interview, she recalls:

> I want to say that when I came here, I used to hiss a lot about the Italians, saying: "Oh, they handed him to the *didornia*!" My husband works there. It's incomparable. Even my client didn't have what they have in the facility.

The term *didornia* is a dialectical word in Ukraine denoting (predominantly public) senior care facilities, and it has a derogatory connotation. Of course, both women are referring to institutional care in Italy, and the same is true of Larysa's imaginary of the future: She is looking for a *struttura* in Italy where others can take care of her. She mentions a residential facility in her hometown and says, "It is very sad there." In Ukraine, public facilities are scarce and underresourced, while private institutions are costly and weakly regulated. As a result, residential care has been widely rejected by older people (see Dutchak et al., 2026). Accordingly, none

of our interlocutors had arranged institutional care for older relatives in Ukraine. In Larysa's case, despite her preference for residential care, her grandmother was looked after by her sister in Ukraine while Larysa provided financial support from abroad.

From Larysa's perspective, however, it is not only the material side of senior care that is better in Italy. Like Maria and Vita in the previous section, she also speaks about a different "mentality" but considers the Italian way of thinking to be a better one:

> They have a different mentality. Starting with the young and ending with the old. For older people, if they have children, Italy is a country where children still take care of their parents. There is an opportunity to hire a woman, a caregiver. There are no questions. It's all in the house; everyone takes care of their parents. If there is no opportunity, or conversely, if it is easier to pay for a *struttura* than for a person to live in the house, they send them to a *struttura*.

Hence, unlike the women with the familialistic imaginaries, for whom "taking care" means performing care directly, for Larysa it may also mean hiring a carer or placing a person in a residential care facility. In doing so, she draws a distinction between living with aging parents and ensuring they receive adequate, often professional, support.

6. A Paid Home Care Imaginary: "So That Someone Is There for Me"

Svitlana is 66, and she migrated to Italy just after the turn of the millennium, where she started to work as an undocumented live-in carer. Over the following years, she legalized her status. Then her husband joined her, and she has been working as a *badante* for over 20 years. While her husband died a couple of years ago, and her daughters migrated to other European countries, Svitlana explains that she "got tired of it," has "no more patience" to continue working in Italy for much longer, and is dreaming and planning to go back to Ukraine in a year or two. On imagining possible care for herself, Svitlana says:

> And why? You can even hire a carer if you need to. You know, if I need that kind of help, so that someone is there for me….I have my own house, all the conveniences. So, you know, if it's necessary, it's necessary. And why not? You have to live out your life somehow.

While explaining her choice to hire a carer if needed, Svitlana talks about the necessity due to her family trajectory: "Well, what should I do if…it's unknown whether my daughters will return to Ukraine, or whether someone will return. Because there's no one left there, you know." Comparing the two care cultures she has experienced, Svitlana notes that some Ukrainians do hire carers for older relatives, though limited finances make this rare. She recalls her late brother, for whom her nephew first arranged live-out and later live-in paid care: "He had everything like in Italy, and even better." Because her nephew worked as an IT specialist abroad and had the means, Svitlana believes that her brother could live out his old age "in peace and dignity." The woman contrasts this story with the story of her sister, who also needed to be cared for in her last years, but her family had to provide the care themselves, as they had no funds to hire anybody: "They didn't have the money to take care of her like we do here in Italy, you know." Svitlana's account thus normalizes paid care and implicitly favors it over family-provided care. Moreover, she expresses regret and guilt about not having been able to arrange comparable support for her late mother.

While Ukraine does not have the classic "migrant in the family" model, and it firmly occupies a "sending country" position in transnational care chains, paid home care is becoming more widespread in Ukraine than institutional care (see Dutchak et al., 2026). Our research suggests that experience working in the transnational care chain, and the impact of migration on families, lead to the normalization of hiring a carer for seniors in Ukraine. As Zoya initially rejected and condemned the idea of residential care for older people, some others have also perceived the idea of a family hiring a carer as "barbaric," even when already working as migrant carers in Italy. With time, though, as the women recall, some started to perceive it as a better option so that an older person "won't be alone." Svitlana and several others express regret that they did not have the financial means to hire a carer for their senior relatives. Some interlocutors also explicitly refer to the necessity of paid care and its normalization due to migration, because "the situation is such that almost everyone has left." This normalization of paid care due to migration is, however, not universal. Zoya, for instance, expresses guilt about unfulfilled family obligations and the moral dilemma of working as a migrant carer while being unable to care for older relatives:

> I have an older sister…she is at home, and she helped my mother, my grandmother. Thank God, we did not have to choose—should we return, should we send this person to the *didornia*, or should we look for somebody…who will help my grandmother. Many have encountered this, and it is a terrible problem. It is a terrible problem, because it is immoral: You take care of one person here. You help, you do not leave, and at home someone takes care of your mother.

The two elements—the normalization of paid home care and the moral obligation of family care—can even be present in the story of one person, which is also the case with Svitlana. Although paid care figures prominently in her imaginary of the future, and she holds actual arrangements of this kind in high esteem in her family, Svitlana also admires the fellow migrants who returned to Ukraine to care for their older parents themselves:

> Even here from Italy now there are women who have gone and are taking care of their father or mother. They accompany them on that last journey and sit with them there. They left Italy, young, but they say: "We have to. This is our duty." And that's very good. And I have such respect for them, great respect. I say: "Oh, this is a nice upbringing."

Conflicting opinions are present not only in Svitlana's story, but in those of other carers too. Zoya, despite framing her two decades in care migration as "not a job," speaks highly of residential care in Italy and envisions paid home care for herself. Maria, though strongly committed to familialistic arrangements, ultimately joined her siblings in hiring a relative to care for a parent. Contradictions between perception of one's job, actual care arrangements and opinions about them, as well as within future imaginaries, were not rare in our research. On the contrary, they were present in the stories, reflections, and imaginaries of the majority of women we talked to, pointing to the very core of care uncertainty and inequalities in transnational care chains.

7. "It Will Be as God Wills": A Discussion of the Contradictions and Uncertainties in Transnational Care Chains

While the literature on future imaginaries often engages with collective or social imaginaries (Oomen et al., 2022; Suckert, 2022), individual imaginaries are part of the puzzle to understanding present inequalities and

related future uncertainties within which people search for their pace and place (Bazzani, 2023; Cantó-Milà & Seebach, 2024; Vignoli et al., 2020). Naturally, contradictions in future imaginaries can be partially attributed to personalities and doubts people commonly have. In line with the literature that interprets imaginaries of the future as "a powerful way of interpreting [the] present as well as the past" (Cantó-Milà & Seebach, 2024, p. 299), we argue that such imaginaries are often firmly situated in the present situation of care migrants: uncertainties in their lives and trajectories in gendered transnational care chains, and their shifting between different welfare and care regimes in the global system of care inequality.

These uncertainties are clearly present in women's narratives: There are many *ifs* and stipulations they voice, trying to envision and imagine their older age. Some of these are framed quite specifically: "If I suddenly end up being alone" or "If my daughter won't come back from another country." Most, however, are abstract and general: "My future will be like everyone else's," "It is unknown what awaits," "It can neither be programmed nor planned," "No one can know that," and repeatedly—"It will be as God wills." This type of narrative demonstrates the lack of control these women feel about their future, conditioned by transnational care inequalities, shaped by their trajectories in transnational care chains, and their lives split between the two countries yet not fully embedded in either.

In separate cases, this unsettlement leads to hardship, almost to the impossibility of imagining care in the migrant's old age. The imaginary can be built around the hope that she will not need care, which, beyond uncertainty, also relates to one's desire to stay independent and to one's fear of becoming a burden for relatives (as in Maria's imaginary: "To say goodbye, go to bed, and never get up again"). In other cases, the uncertainties can even lead to negation and the rejection of both the future and care altogether: "I won't need to be cared for," "I'll tell you the truth; I won't live to retire," or "If I live to see old age at all." This impossibility of imagining adequate care for them or hoping it will not be needed reflects the radical absence of a visible track between where they are now and their idea of sustainable aging and senior care.

In other words, some of these women feel that there is no good place for their aging—neither in Italy, nor in Ukraine, as they are (dis)located between the two countries—"You are neither here nor there," says one of them. Another explains:

> And our Ukrainians get such a tiny pension in Italy. And, indeed, it's a very sad picture here. I don't know where they will be. It's good that they have some men with whom they live, but no one is obliged to take care of them. Some women I know, they don't even have anywhere to return home…and they don't want to return to Ukraine themselves, because they have already become estranged from their relatives.

Yet another layer of instability in their life situations and future prospects was added after 2022 with Russia's full-scale invasion of Ukraine. While some of the women still plan to return home, or dream of going back, others say they have started going to Ukraine less frequently, and their doubts about possible aging there have increased. For some, these doubts are partly due to their families fleeing the country because of war. Hence, they have nobody to go back to, and nobody to expect care from there. For others, the doubts are caused by the physical danger, the resulting economic crisis, the decline in social provisioning, and the increasing unpredictability of the country's future in general:

> How can I say now that I want to be in Ukraine? How will I get to Ukraine? Will I wait until the children have to give me a piece of bread? If I am healthy, I will work, and I will have my piece of bread….If I saw that there was work in Ukraine, that the war was over, jobs had appeared, then the situation would be different—I would leave everything and go. And if I see that there is a war in Ukraine, then where should I go?…I don't know. I don't see the point in going home now.

Despite widespread feelings of limited control, some of the Ukrainian care workers in Italy not only try to imagine what is coming, but also build narratives of the future, describing a relatively planned path toward sustainable aging and strategies they employ to cope with future uncertainty. Many of these strategies concern material security in later life. For instance, women may own property in Ukraine (as in Larysa's reference to her "house with all the conveniences" in her imaginary), or acquire housing in Italy during their working lives. Others envision access to an Italian pension, contingent on long-term legal employment. Finally, some save money specifically for when they are older.

Saving, however, contradicts one of the roles commonly assigned to migrant women in Ukraine. The decision to "leave children behind" challenges the dominant gendered norms of motherhood and is typically legitimized through the narrative of "migration as sacrifice" (Fedyuk, 2012; Tyldum, 2014), in which earnings are remitted to the family. Yet our research shows that some women emphasize saving as a necessary strategy, often encouraged by fellow migrants or close family members—most commonly adult children. This orientation is also promoted by parts of the Ukrainian Church in Italy. Given the large presence of migrant women in their congregations, some church representatives are closely acquainted with their lives and actively intervene in support of a more concretely planned future. As Svitlana explains:

> My daughter says, "You should save up for yourself so that you have something for old age." How long will that old age be?…This is life, unpredictable. But it's better to have something to fall back on. The priest always tells us that. Always, for many years now….He keeps saying: "Be wise, don't give everything to your children, don't give everything to your grandchildren—leave some money for yourself. God forbid, you get sick, or you return home"….It's true, you know. Because I even had such acquaintances, a friend, and she gave away all her money, down to the last penny. And then she didn't even have enough to top up her phone.

Another of our interlocutors' strategies for dealing with uncertainty was to rely on personal relations. These are, first of all, preexisting family relations: Women can expect that their constant support for their family will be reciprocated through family support and care for them in old age: "My daughter and my good son-in-law are waiting for me….I think they won't kill me, because I supported them. They're not like that, so I think everything will be fine. I have hope in God and in them." Other women can rely on their intimate relationships or a marriage to a local man as a way of settling their present and future; one of the women we talked with married a close relative of an older lady she cared for. Another married a more settled fellow Ukrainian migrant. Sometimes the material and personal relations strategies closely link and even intersect, forming a complex moral economy of migration (Fedyuk, 2021). For example, one woman hopes that the value of her house back in Ukraine and the prospects of inheriting it after her death can secure care from her relatives in the future. Another got her Italian apartment because of her close personal relation with a senior client—she inherited it after the client's death.

In any case, most of the migrants' strategies for dealing with uncertainty are individual and individualized. While the individualization of the future has become a general trend in the context of neoliberal globalization (Cantó-Milà & Seebach, 2024, p. 303), the individualization of these women's futures is additionally amplified by the lack of any actual systemic solution to the challenges of migrants' aging. In her search for a more collective path, Zoya shares an internal joke present among her fellow migrants: "We laugh—there are friends with families here—we say to them, 'Oh, what loans, what apartments, let's buy a *didornia*, buy one for Ukrainians. We will play Ukrainian music; they will take care of us.'" She says this as a joke, while a priest from the Ukrainian Church in Italy articulated the same idea as an actual proposal. This suggests that the Ukrainian Greek Catholic church, as a key institutional actor in migrants' lives, does not anticipate support for them in old age coming from elsewhere.

Finally, despite having very different care imaginaries, two of our interlocutors expressed their dream to open a *struttura* after going back to Ukraine—to apply their experience in senior care back at home, because, as Vita explained, she wants "to see our grannies and grandpas [to be taken care of] like here." While it does run along similar lines to others' desires to contribute to their families, communities, and home society—in their words: "To give back my love," "To do something useful," and "To join in with something"—Larysa's and Vita's future imaginaries are saturated with their professional experience in the Italian care sector, and they are driven by the will to apply it to make a difference, no matter how vague the prospects for realizing those imaginaries may be.

8. Conclusion

In summary, in this article we have argued that migrants' engagements in transnational care chains shape and restrict the possibilities of care arrangements they see and wish for—because of care inequalities, on the one hand, and because of migrants' professionalization, on the other. By exploring the relations between the lived experience of senior-care work, migration, and transnational care chains with the migrants' imaginaries of their own future, we noticed that these connections are not straightforward. Their imaginaries are shaped by experiences of transnational care chains, in which care work is both a professional career and a family obligation. In between these two poles of care obligations, women predominantly find little stability, structural support, or clarity regarding their own prospects in old age.

Furthermore, the three groups of care imaginaries we identified among Ukrainian migrant care workers in Italy are impacted by both the cultural attitudes they carry over from the Ukrainian familialistic model, and those attained through formal and informal professionalization while working in the Italian senior care sector. And while the link between the various imaginaries and their professional trajectories is ambiguous, it is more visible for those who passed through the bottleneck of formal professionalization.

Our research confirms the conclusion in the existing literature that projective capacities are not equally distributed among the population (Bazzani, 2023; Suckert, 2022) and interlink with socioeconomic inequalities. While, for some of the women, imagining future care is close to impossible, certain others nevertheless attempt to build a narrative of the future. In so doing the women are trying to counteract the uncertainty of their future care through a number of strategies. Some rely on family relations, placing hope in children returning the favor after their years-long financial support. Others feel empowered by professionalization, relying on building up their (often-limited) labor-entitled welfare, savings, and the roof

over their head, either acquired or sustained during their working lives. When (dis)location is present, Ukrainian care migrants predominantly rely on their own resources and individual solutions to counteract the systemic uncertainty of their future aging and care. This perfectly fits in with the logic of the migration labor force as described by Berger, Anderson, and others: It is replaceable and self-sustained, and it will take care of itself. This conclusion mirrors the gendered critique of transnational care migration, which states that migrant women shoulder not only low-paid challenging jobs in difficult working conditions but also carry the burden of absent transnational agreements and national welfare regimes, which are increasingly withdrawing from the spheres of care and social protection.

With the exception of those few imaginaries about senior care in a *struttura*, there is hardly any state—neither Ukrainian, nor Italian—visible in the women's future. Their years-long embeddedness in transnational care chains produces a (dis)location of care for these migrants caught between the two welfare systems, with no proper place for their aging in either. This (dis)location, combined with an unsettled migration status, inequalities linked to transnational care chains, and often loosening family relations because of the distance, all create feelings of uncertainty about the future and their lack of control over it. All this results in care migrants' imaginaries often being controversial, bouncing back and forth between desirable and undesirable, possible and unpredictable, as women imagine their future in the system of care inequality, where no clear-cut path to aging with dignity exists for them.

The rarest imaginary regarding possible solutions for migrants' aging was the dreaming about community care. On seeing the adequate care in the Italian residential facilities, the women also see that they are hardly entitled to a place there—as they are not entitled anywhere. The ideas of a community, a *struttura*, that could be organized for aging workers, a theme that we saw recurring in our interviews, points to an important realization: an attempt and a manifestation of the women's desire to reclaim their agency despite the care inequalities embedded in their life and work in Italy, and against all odds.

Acknowledgments

We express gratitude to the research participants who shared with us their experiences of care migration. We are grateful to Andrew Hodges for proofreading the text.

Funding

This work was supported by the Volkswagen Foundation within the program Challenges and Potentials for Europe.

Conflict of Interests

In this article, editorial decisions were undertaken by Ulf R. Hedetoft (University of Copenhagen).

Data Availability

The ethnographic data on which this study is based are confidential and cannot be shared in accordance with research ethics commitments made to participants.

LLMs Disclosure

OpenAI's ChatGPT (GPT-4) was used to improve the grammar of the text.

References

Al-Hamad, A., Yasin, Y. M., Guruge, S., Metersky, K., Wang, L., Catallo, C., Amanzai, H., Zhuang, Z. C., Rahman, R., & Zhang, A. (2025). Equitable aging among migrants: A concept analysis and model development for transcultural nursing care. *Journal of Transcultural Nursing*, *36*(6), 644–660.

Anderson, B. (2000). *Doing the dirty work? The global politics of domestic labour*. Zed Books.

Ayalon, L. (2021). The global care network and its impact on sending and receiving countries: Current knowledge and future directions. *Ageing & Society*, *42*(10), 2244–2261.

Ayalon, L., & Rapolienė, G. (2022). Changes in attitudes toward aging, older people and elder care from the perspective of former migrant care workers. *Research on Aging*, *44*(7/8), 611–618.

Baas, M. (2015). Return migration/the returning migrant: To what, where and why. In M. Baas (Ed.), *Transnational migration and Asia: The question of return* (pp. 7–8). Amsterdam University Press.

Bastia, T., Lulle, A., & King, R. (2022). Migration and development: The overlooked roles of older people and ageing. *Progress in Human Geography*, *46*(4), 1009–1027.

Bazzani, G. (2023). Futures in action: Expectations, imaginaries and narratives of the future. *Sociology*, *57*(2), 382–397.

Berger, J., & Mohr, J. (1989). *A seventh man*. Granta Books. (Original work published 1975)

Brandhorst, R., Baldassar, L., & Wilding, R. (2019). The need for a 'migration turn' in aged care policy: A comparative study of Australian and German migration policies and their impact on migrant aged care. *Journal of Ethnic and Migration Studies*, *47*(1), 249–266.

Brettell, C. (1979). Emigrar para voltar: A Portuguese ideology of return migration. *Papers in Anthropology*, *20*(1), 1–20.

Bryant, R., & Knight, D. M. (2019). *The anthropology of the future*. Cambridge University Press.

Cantó-Milà, N., & Seebach, S. (2024). Between temporalities, imaginaries and imagination: A framework for analysing futures. *European Journal of Social Theory*, *27*(2), 298–313.

Carlsson, H., & Pijpers, R. (2021). Diversity-mainstreaming in times of ageing and migration: Implementation paradoxes in municipal aged care provision. *Journal of Ethnic and Migration Studies*, *47*(11), 2396–2416.

Cassarino, J. P. (2004). Theorising return migration: The conceptual approach to return migrants revisited. *International Journal on Multicultural Societies*, *6*(2), 253–279.

Ciobanu, R. O., Fokkema, T., & Nedelcu, M. (Eds.). (2019). *Ageing as a migrant: Vulnerabilities, agency and policy implications*. Routledge.

Dustmann, C. (1996). Return migration: The European experience. *Economic Policy*, *11*(22), 213–250.

Dutchak, O. (2024). Caring for Ukraine: Care and social reproduction in wartime Ukraine. *Transform Review: European Review of Politics*, *1*, 66–85.

Dutchak, O., Fedyuk, O., & Oksiutovych, A. (2026). Senior care in wartime Ukraine: A fragmented continuum of arrangements inside an "unpromising sector". *Social Inclusion*, *14*, Article 12060.

Fedyuk, O. (2012). Images of transnational motherhood: The role of photographs in measuring time and maintaining connections between Ukraine and Italy. *Journal of Ethnic and Migration Studies*, *38*(2), 279–300.

Fedyuk, O. (2021). Moral economies of intimacy: Narratives of Ukrainian solo female migrants in Italy. In H. Haukanes & F. Pine (Eds.), *Intimacy and mobility in an era of hardening borders* (pp. 33–50). Manchester University Press.

Fedyuk, O. (2025). 'An ordinary business dealing with extraordinary circumstances': Deathwork and mediation in the case of Ukrainian transnational funeral services for migrants in Italy. *Mortality*. Advance online publication. https://doi.org/10.1080/13576275.2025.2592813

Hunter, A. (2018). *Retirement home? Ageing migrant workers in France and the question of return*. Springer Nature.

Istituto Nazionale di Statistica. (2022). *Cittadini non comunitari in Italia—Anni 2021–2022*. https://www.istat.it/it/files/2022/10/Report-cittadini-non-comunitari-2022.pdf

Jones, R. L. (2011). Imagining old age. In J. Katz, S. Peace, & S. Spurr (Eds.), *Adult lives: A life course perspective* (pp. 18–26). Policy Press.

Kristiansen, M., Kessing, L. L., Norredam, M., & Krasnik, A. (2015). Migrants' perceptions of aging in Denmark and attitudes towards remigration: Findings from a qualitative study. *BMC Health Services Research*, *15*(1), Article 225.

Kröger, T., & Zechner, M. (2009). Migration and care: Giving and needing care across national borders. *Finnish Journal of Ethnicity & Migration*, *4*(2), 17–26.

Lados, G., & Hegedűs, G. (2016). Returning home: An evaluation of Hungarian return migration. *Hungarian Geographical Bulletin*, *65*(4), 321–330.

Lang, T. (Ed.). (2013). *Return migration in Central Europe: Current trends and an analysis of policies supporting returning migrants*. Leibniz-Institut für Länderkunde.

Leifsen, E., & Tymczuk, A. (2012). Care at a distance: Ukrainian and Ecuadorian transnational parenthood from Spain. *Journal of Ethnic and Migration Studies*, *38*(2), 219–236.

Lutz, H. (2018). Care migration: The connectivity between care chains, care circulation and transnational social inequality. *Current Sociology*, *66*(4), 577–589.

Lutz, H., & Palenga-Möllenbeck, E. (2012). Care workers, care drain, and care chains: Reflections on care, migration, and citizenship. *Social Politics*, *19*(1), 15–37.

Marchetti, S., & Venturini, A. (2013). Mothers and grandmothers on the move: Labour mobility and the household strategies of Moldovan and Ukrainian migrant women in Italy. *International Migration*, *52*(5), 111–126.

Martin, R., & Radu, D. (2012). Return migration: The experience of Eastern Europe. *International Migration*, *50*(6), 109–128.

McGrath, M., Bagul, D., & Du Toit, S. H. (2022). Barriers and facilitators of meaningful engagement among older migrants living with dementia in residential aged care facilities: A mixed studies systematic review. *Scandinavian Journal of Occupational Therapy*, *29*(7), 530–541.

Mudrak, V. (2011). *The Italian-Ukrainian care chain: Transnational welfare, transnational families and care drain* [Unpublished master's thesis]. Lund University.

Odynets, S. (2021). Keeping it in the family: Rotating chains in women's transnational care work between Italy and Ukraine. In O. Ryndyk, B. Suter, & G. Odden (Eds.), *Migration to and from welfare states: Lived experiences of the welfare-migration nexus in a globalised world* (pp. 33–47). Springer.

Oomen, J., Hoffman, J., & Hajer, M. A. (2022). Techniques of futuring: On how imagined futures become socially performative. *European Journal of Social Theory*, *25*(2), 252–270.

Pink, S., Akama, Y., & Fergusson, A. (2020). Researching future as an alterity of the present. In J. F. Salazar, S. Pink, A. Irving, & J. Sjöberg (Eds.), *Anthropologies and futures* (pp. 133–150). Routledge.

Radziwinowiczówna, A., Rosińska, A., & Kloc-Nowak, W. (2018). *Ethnomorality of care: Migrants and their aging parents*. Routledge.

Ryan, L. (2007). Migrant women, social networks and motherhood: The experiences of Irish nurses in Britain. *Sociology*, *41*(2), 295–312.

Solari, C. (2017). *On the shoulders of grandmothers: Gender, migration, and post-Soviet nation-state building*. Routledge.

Strelnyk, O. (2026, January 29). "Mama sto vidsotkiv na meni": Simeine pikluvannia pro liudei starshoho viku v hendernomu i klasovomu vymirakh. *Spilne/Commons*. https://commons.com.ua/uk/simeine-pikluvannia-pro-liudei-starshoho-viku

Suckert, L. (2022). Back to the future. Sociological perspectives on expectations, aspirations and imagined futures. *European Journal of Sociology/Archives Européennes de Sociologie*, *63*(3), 393–428.

Tılıç-Rittersberger, H., Çelik, K., & Özen, Y. (2011, April 6-9). *Returning to "Home" from Germany: Reasons and dynamics of return migration* [Paper presentation]. Migration: Economic Change, Social Challenge, London, United Kingdom.

Tyldum, G. (2014). Motherhood, agency and sacrifice in narratives on female migration for care work. *Sociology*, *49*(1), 56–71.

Vakhitova, H., & Fihel, A. (2020). International migration from Ukraine: Will trends increase or go into reverse? *Central and Eastern European Migration Review*, *9*(2), 125–141.

van Hooren, F. J. (2012). Varieties of migrant care work: Comparing patterns of migrant labour in social care. *Journal of European Social Policy*, *22*(2), 133–147.

Vianello, F. A. (2016). Migration of Ukrainian nationals to Italy: Women on the move. In O. Fedyuk & M. Kindler (Eds.), *Ukrainian migration to the European Union: Lessons from migration studies* (pp. 163–178). Springer.

Vignoli, D., Bazzani, G., Guetto, R., Minello, A., & Pirani, E. (2020). Uncertainty and narratives of the future: A theoretical framework for contemporary fertility. In R. Schoen (Ed.), *Analyzing contemporary fertility* (pp. 25–47). Springer.

World Health Organization. (2017). *Women on the move: Migration, care work and health*.

World Health Organization. (2018). *Health of older refugees and migrants: Technical guidance*.

About the Authors



Oksana Dutchak holds a PhD in sociology from the Kyiv Polytechnic Institute. Her research focuses on social reproduction, gender inequality, care labor, and care migration. She is devoted to engaged research, which contributes to public discussion and policies, trying to give a voice to workers and other structurally underprivileged groups.



Olena Fedyuk holds a PhD in social anthropology from Central European University. Her research focuses on transnational labour migration, gendered work, labour sourcing agencies, and migrant workers' rights through action research. She is interested in feminist-informed research methodologies and has developed expertise in qualitative and visual methods, including documentary filmmaking.



Anna Oksiutovych is a social researcher with a background in feminist activism and informal education. Her areas of interest and research include labor rights, youth work, gender and migration, and childhood during war.

Social Inclusion
2026 • Volume 14 • Article 12326
https://doi.org/10.17645/si.12326

cogitatio

ARTICLE

Open Access Journal

The Winding Road to Professionalisation: Care Work in Romanian Nursing Homes

Neda Deneva [1], Ionuț Földes [1], Denisa Ursu [2], and Mihaela Hărăguș [3]

[1] Department of Sociology, Babeș-Bolyai University, Romania
[2] Doctoral School in Sociology, Babeș-Bolyai University, Romania
[3] Centre for Population Studies, Babeș-Bolyai University, Romania

Correspondence: Neda Deneva (faje.deneva@ubbcluj.ro)

Submitted: 3 March 2026 **Accepted:** 29 June 2026 **Published:** 29 July 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Across Central and Eastern Europe, the expansion of formal long-term care provision has intensified questions regarding the organisation, recognition, and professionalisation of care work. Romania offers a particularly relevant case, as the rapid growth of residential care for older persons has created new institutional spaces where care is increasingly organised as paid work. Despite the legal regulation of occupations in this field, occupational roles overlap in practice, and employers recruit a substantial share of workers without prior qualifications, while skills are acquired through short courses, peer learning, and on-the-job experience. This article examines these processes of professionalisation in Romanian nursing homes, focusing on how overlapping roles, emotional labour, and tacit knowledge shape everyday care practice. Drawing on qualitative interviews with care workers and managers in private nursing homes, the findings reveal fluid professional boundaries, with medical, non-medical, and relational responsibilities frequently overlapping. Professionalisation emerges slowly and unevenly, not through institutional reform or credentialisation alone, but through workers' everyday adaptation, informal learning, and the practical negotiation of professional roles under conditions of labour shortages and limited institutional support.

Keywords

care work; nursing homes; professionalisation; Romania

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Care arrangements for older people in Romania have undergone gradual transformation over the last two decades. While family care continues to dominate and remains the socially preferred model, demographic ageing, migration, changing household structures, and increasing care intensity have expanded the role of formal care provision (Hărăguș & Földes, 2026; World Bank, 2022). Among formal services, private residential facilities have grown particularly rapidly and have become an increasingly important site for organising long-term care (LTC) through salaried labour (European Commission, 2022). This expansion introduced new occupational roles and intensified recruitment and retention pressures, while bringing care work into institutional settings marked by labour shortages and weak role differentiation. Residential care remains socially ambivalent and often treated as an exceptional arrangement, reflecting the continued dominance of familial care norms (Bó et al., 2020; Dohotariu & Băluță, 2021). Despite the centrality of the care workforce to the quality and sustainability of residential provision, little is known about how care work is organised and professionalised within Romanian nursing homes.

Care work has increasingly been analysed not simply as moral obligation but a form of socially necessary labour that remains systematically undervalued despite sustaining welfare systems and social reproduction (England, 2005; Folbre, 2001). At the same time, professionalisation scholarship has moved beyond classical models centred on occupational closure and credentialing to emphasise more uneven and organisationally embedded forms of competence formation (Bellini & Maestripieri, 2023; Evetts, 2011). This shift is particularly relevant for care work, where expertise often develops under conditions of fragmented institutional support and limited occupational autonomy and extends beyond formal qualifications to include relational, emotional, and practical forms of competence (Hochschild, 2015; Mol et al., 2010). Such dimensions of care work remain difficult to formalise, measure, and translate into recognised professional status and remuneration, making care an especially productive site for examining how professionalisation takes shape in practice and under which conditions it remains partial or constrained.

Against this background, our article asks: What forms of professionalisation can be identified in care work in Romanian nursing homes, and which institutional and organisational conditions shape and constrain this process? Drawing on the concepts of professionalisation, emotional labour, and tacit knowledge, we examine how professional competence is produced, recognised, and negotiated under conditions of labour shortages, weak institutional support, and fluid occupational boundaries. Empirically, the article draws on qualitative research conducted in private nursing homes in Cluj-Napoca and its peri-urban area, combining interviews with care workers and managers to connect formal definitions of professional roles with institutional organisation and everyday care practices.

While existing literature often frames professionalisation as an organised process, we show that under-resourced settings rely on informal bottom-up negotiation, on-the-job learning, and workers' everyday adjustments, while remaining only partially recognised and rewarded. Changes toward more defined job roles are slow and arise primarily from workers' own practice, whereas managers are chiefly preoccupied with labour shortages and staff retention rather than clarifying professional boundaries. Formalised qualifications are not a precondition for hiring, and care workers routinely assume a broad range of tasks while informally negotiating their roles. As a result, professional identities are shaped less by certification than by capacities such as patience, flexibility, and emotional resilience.

Below, we first present the context and institutional background of Romania's care landscape. We then ground our work with key concepts. We subsequently detail the methodological premises of our research. Finally, the analysis section is divided into two parts to reflect care workers' and managers' differing interpretations regarding key aspects of the process.

2. The Landscape of Care for Older Persons in Romania

Care for older persons emerged relatively late on the Romanian political agenda, largely in connection with preparations for EU accession, and it has been framed in political discourse as primarily a family responsibility (Dohotariu & Băluță, 2021). Historically, Romanian family policy has been geared towards demographic objectives rather than supporting carers or building comprehensive long-term care systems for dependent adults (Inglot et al., 2022). Care for dependent older adults has consequently remained marginal within the family-policy framework, reinforcing reliance on informal, family-based provision. Informal care delivered by family members thus dominates the Romanian care landscape (Hărăguș & Földes, 2026; World Bank, 2022, p. 70), placing the country within the implicit familialism category regarding the distribution of care responsibilities between family, state, and market (Leitner, 2003; Saraceno & Keck, 2010). This familialist arrangement is underpinned by cultural norms that organise care along gendered lines, typically carried out by female family members (Bó et al., 2020; Precupetu et al., 2019). As per an unpublished finding from the CareOrg project, there is a strong preference for ageing at home with familial support. Public trust in residential care has been further eroded by recurrent quality scandals, most visibly investigative reporting in early 2023 (Buletin de București, 2023) exposing severe neglect in several privately operated centres, and the social acceptability of institutional care remains correspondingly low.

The most recent LTC strategy adopts respect for autonomy and freedom of choice—including the choice of care setting—as a guiding principle and prioritises home and community-based care together with support for informal carers and the prevention of institutionalisation. Implementation, however, has remained partial with reliance predominantly on family-based care and limited use of formal services (Hărăguș & Földes, 2026; World Bank, 2022). Romania records lower rates of home-care use than most European countries, and the overall reach of formal services remains limited, particularly in rural areas and for low-income households.

Within the formal care sector, residential facilities dominate the Romanian LTC landscape in terms of accredited providers, budgets, staff, and infrastructure. These facilities are predominantly private and tend to be small or medium-sized. The sector has expanded rapidly, driven by demand outstripping public capacity (European Commission, 2021), with private residential facilities rising from 235 in 2017 to 674 in 2026 (Ministry of Labor, Family, Youth and Social Solidarity, 2026; World Bank, 2022, p. 70), though this expansion has remained territorially uneven. Provision is governed by a uniform accreditation regime, though quality monitoring remains weak and evaluation tends to be one-sided rather than participatory (Ghența & Matei, 2024). The cost of LTC is shared between central, regional, and local authorities and the beneficiaries themselves, who pay the highest share of the costs, far exceeding average pensions. This effectively restricts access to those with substantial private resources, leaving low-income older people especially vulnerable (Hărăguș & Földes, 2026).

The decentralised structure of the system further exacerbates these inequalities. Responsibility for social services rests with local authorities, allowing flexibility but also fragmenting provision because service

capacity depends more on local budgets than on care needs (World Bank, 2022). Indicators of demographic ageing are negatively correlated with the presence of nursing homes, suggesting that areas carrying the heaviest ageing burden often have the fewest formal care resources (as per unpublished findings from the same project). Economic capacity, therefore, shapes the distribution of formal care more strongly than demographic need.

This fragmented, privately dominated, and weakly monitored residential sector, where access reflects economic capacity more than care need, provides the institutional context in which questions of who provides care, how care work is organised, and whether and how it becomes professionalised become particularly salient.

3. Care Work as Professional Category and Moral Obligation

Care work has increasingly been analysed as a central component of contemporary welfare regimes and labour markets, rather than as a private or purely moral activity. Feminist political economy has shown that care constitutes a form of socially necessary labour supporting life and social reproduction, while remaining structurally undervalued because it is historically associated with women and the family (England, 2005; Folbre, 2001). Research on the feminisation of care labour demonstrates how care occupations are devalued through their association with women's presumed natural dispositions, which contributes to segmented labour markets and precarious working conditions (Palenga-Möllenbeck, 2013). Building on this perspective, Razavi (2007) conceptualises care as being located at the intersection of state, market, family, and community arrangements, demonstrating how care regimes shape the distribution of responsibilities, labour conditions, and professional recognition. Comparative research shows that reforms such as marketisation, cash-for-care schemes, and privatisation have often prioritised cost containment and service expansion while paying limited attention to job quality, contributing to precarious care labour markets (van Hooren, 2012; van Hooren et al., 2019). Care consequently occupies an ambiguous position simultaneously as paid work and as a moral relationship, creating tensions around which forms of competence become visible, valued, and recognised as professional labour. Understanding care as work, therefore, requires attention to its material conditions and the normative expectations that frame it.

3.1. Care Work in the Process of Professionalisation

Professionalisation is commonly understood as the process through which occupations acquire recognised expertise, legitimacy, and authority over a defined domain of work. Classical sociological approaches conceptualise this process as involving the institutionalisation of specialised knowledge, the establishment of occupational boundaries, and the achievement of social recognition and professional autonomy (Abbott, 1988; Larson, 1977). Training and formal qualifications occupy a central place in this process, as they codify expertise, regulate entry, and distinguish one occupational group from another (Evetts, 2014; Tholen, 2017). Professional status, therefore, depends not only on the performance of tasks but also on the social recognition of particular forms of knowledge as legitimate, exclusive, and worthy of protection.

Early formulations conceptualise professionalisation as a professional project: a collective and strategic effort through which occupational groups translate expertise into labour market control, occupational closure, social recognition, and professional autonomy (Larson, 1977). Such approaches assume coherent pathways of

professional development supported through credentialing, boundary work, and institutional recognition. More recent scholarship has questioned whether contemporary forms of professional work follow such trajectories and distinguish between occupational professionalism—grounded in collective control over norms and practice—and organisational professionalism—shaped through managerial regulation and standardisation (Evetts, 2011). Bellini and Maestripieri (2023) emphasise heterogeneity, organisational embedding, and the diversification of pathways through which professional competence is produced and recognised, rather than assuming stable professional boundaries and coherent professional projects. From this perspective, professionalisation may unfold unevenly and remain incomplete, particularly in sectors that experience organisational instability, labour shortages, fragmented authority, and fluid occupational boundaries.

This distinction is relevant in care settings, where institutions often shape standards, role definitions, and expectations rather than occupational groups collectively negotiating them. Care occupations occupy an ambiguous position within professional hierarchies because they combine formal, relational, and practical forms of expertise that are difficult to stabilise within conventional professional categories (Wrede et al., 2008). The professionalisation of nursing home workers and home care workers is often characterised by fragmented training systems, low entry barriers, and fluid occupational boundaries (Daly & Lewis, 2000; Meagher & Szebehely, 2013). As a result, care work remains under-recognised professionally despite requiring complex competencies produced in practice.

3.2. The Value of Emotional Labour

The maintenance of low formal entry requirements and blurred occupational boundaries contributes to the classification of care work as "low-skilled" labour. Feminist sociology of work has shown that when emotional and affective labour is framed as a natural disposition, especially for women, it is excluded from what is considered professional expertise. Building on Hochschild's understanding of emotion management as central to producing "the sense of being cared for in a convivial and safe place" (Hochschild, 1983) and her later discussion of emotional surplus value, emotional engagement is not simply individual disposition but can be understood as productive labour that generates value while remaining difficult to formalise and remunerate (Hochschild, 2015). Research on emotional labour in healthcare and care settings shows that this dimension of work tends to remain secondary to technical forms of competence that are more easily standardised and measured (Bolton, 2005; Riley & Weiss, 2016; Theodosius, 2008). Emotional competence—central to producing good care—thus remains weakly recognised as a skill and poorly translated into professional status and remuneration.

In this framing, emotional labour is idealised as a freely given personal commitment, while its status as labour is obscured, becoming marginal in how professional competence is defined, reinforcing low pay and low status. The emotional labour of carers is naturalised as a "serving heart" that brings a "second pay cheque" in the form of gratitude and hugs rather than wages (Johnson, 2015). In what follows, we analyse how this misrecognition is reproduced in Romanian nursing homes by both managers and workers in the way they approach and talk about "working from the heart" as indispensable, while rarely describing it as a skill that might be trained, evaluated, or formally recognised as part of the care worker's professional profile.

3.3. Tacit Knowledge and the Practice of Care

In a setting where formal training remains partial and fragmented and occupational boundaries are unstable, knowledge is accumulated through experience, informal exchange, and practice. The concept of tacit knowledge becomes a useful lens for thinking about how care workers develop competencies in Romanian nursing homes. Following Polanyi (1966), tacit knowledge refers to forms of "knowing how" that cannot be fully articulated through explicit rules. In health and social care, this has been described as practical judgement or "clinical craftsmanship," built through experience of concrete situations and expressed in the capacity to act appropriately without formal guidance (Benner, 1984).

Mol's (2008) analysis of care emphasises that good care is not the mechanical implementation of standardised procedures but a process of ongoing adjustment and coordination within material conditions and relational dynamics. Care practices rely on "tinkering," a continuous process of adapting actions, technologies, and relationships to shifting needs rather than applying general rules (Mol et al., 2010). From this perspective, expertise in care work is not absent; it is embedded in practice and remains only partially visible within credential-based definitions of professionalism.

In long-term support for dependent people, a high-quality professional–client relationship is not an optional moral supplement but a precondition for professional judgement (Reinders, 2010). Insight into a person's needs develops through sustained engagement and the ability to interpret situations, moods, and everyday changes over time. When quality is reduced to measurable indicators and standardised interventions, the relational and interpretive work through which professionals gain insight into residents' needs becomes invisible.

Taken together, these perspectives suggest that we cannot understand professionalisation in care solely through formal indicators such as credentialing, occupational closure, or role differentiation. Emotional labour and tacit knowledge point to forms of expertise produced through practical engagement, relational work, and situated judgement but remain difficult to formalise, measure, and reward. Building on this perspective, we approach Romanian residential care not as a case of incomplete transition towards an already established professional model, but as a setting in which professionalism is actively negotiated in everyday practice. The care workers in our study do not appear to engage in a professional project in Larson's sense, nor do they aim to exercise strong occupational control over standards, training, or entry into the field. Rather, as the empirical material will demonstrate, professional competence is developed and sustained through everyday work, informal learning, practical adaptation, and collective processes of knowledge sharing among workers. Professionalisation, therefore, appears less as an organised project than as a dispersed and uneven process that emerges under conditions of limited institutional support and fluid occupational boundaries.

4. Methodology

Our study focuses on private nursing homes for older persons in Cluj-Napoca and its peri-urban area. Most accredited residential care centres in Romania are private providers operating as NGOs. Public and socio-medical facilities remain important but operate under different organisational and funding arrangements and were therefore excluded from the analysis. The choice of private facilities also reflects the symbolic terrain on which care decisions are made, where placing a dependent relative in a private facility

eases the dissonance between the norm of "good care" at home and institutional care, which continues to carry associations with poor nursing homes from the socialist period. Private nursing homes are thus the dominant form of provision and the setting where care unfolds as paid, organised, and professionalised work.

Cluj County was selected as the empirical setting because it represents an economically stronger region in which residential care provision has expanded rapidly, reflecting broader national patterns of care infrastructure concentrating in areas with greater institutional and economic capacity. Of the 795 licensed residential facilities for older persons in Romania, 51 are located in Cluj County.

The article draws on qualitative methodology. We conducted 19 semi-structured interviews with care workers and 6 with managers of private nursing homes in Cluj-Napoca and its peri-urban area between May 2024 and February 2025. Interviews with care workers explored pathways into care work, formal qualifications and skill acquisition, everyday tasks, emotional labour, and perceptions of professional recognition. Particular attention was paid to how workers interpret professional categories such as *infirmieră* (nurse assistant) and *îngrijitoare* (care assistant) and how these categories function in practice. Interviews with managers focused on staff recruitment and retention, compliance with regulatory standards, and financial constraints.

Since Cluj-Napoca and its surroundings are ethnically mixed (around 17% of the population in Cluj County identifies as Hungarian), the workforce in nursing homes included both Romanian- and Hungarian-speaking care workers. We conducted interviews with representatives from both ethnic groups. Ethnic and linguistic background were considered during the analysis. However, across the themes covered in the interview guide, no systematic differences emerged.

Participation in the study was voluntary and based on informed consent. Respondents were informed about the aims of the research and the use of interview material. To protect confidentiality, the institutions are anonymised, and quotations are not linked with concrete respondents. The interviews were conducted by members of the research team in Romanian and Hungarian, depending on participants' preference. The researchers were external to the institutions and did not hold managerial or regulatory roles within them.

Interviewed care workers were women aged 37 to 57, in their late 40s and 50s. Several had previous migration experience in care work, and their educational backgrounds varied from shorter training programmes to formal nursing assistant qualifications. Across the sample, respondents combined mixed formal credentials with substantial reliance on practical experience and peer learning.

The interviews were transcribed and analysed using thematic analysis supported by MaxQDA. We reviewed the interview material and identified recurring themes, emerging patterns, and preliminary analytical observations. Coding focused on how care workers and managers described professional roles, everyday work practices, training, and institutional conditions. Additional themes emerged through repeated engagement with the material and comparison across interviews. Particular attention was paid to tensions between formal occupational definitions and everyday care practices and the respondents' understanding of competence, professional boundaries, and care work.

5. Care Workers and Everyday Professionalisation

5.1. Professional Categories

In Romanian residential care facilities, *infirmieră* (nurse assistant) and *îngrijitoare* (care worker) are formally classified as distinct occupational categories within the Romanian Classification of Occupations (COR). Nurse assistants (COR 532103) receive recognised hygiene training and are qualified to provide personal hygiene care, assist with food and mobility, monitor vital signs, prevent pressure sores, and support basic non-invasive medical procedures under a nurse's supervision. Care workers (COR 532104) belong to the social care sector and are expected to provide assistance with daily living activities, including washing, dressing, cleaning, emotional support, and social activities, but not medical support. In practice, this boundary is much less clear in nursing homes, where persistent staff shortages and non-standardised work norms make the two roles overlap and become functionally similar. Workers are often recruited without formal qualifications, with some being hired under cleaning contracts and later reclassified after completing basic training. Skills are often acquired through practice, peer learning, or online resources, while structured professional development remains limited. In what follows, we examine how these formal categories operate in everyday care practice and how their boundaries are negotiated.

5.2. Everyday Practices of Care Work

Care workers describe their professional role not through formal definitions, but through the accumulation of tasks that structure their daily shifts. Their accounts describe a fluid and mixed form of labour in which professional boundaries are continuously stretched. Instead of referring to distinct occupational categories, many speak about "doing everything." One worker explains: "I didn't just care for the sick. I also gave medication, cleaned….Here we help with food and feeding too." The overlap with nursing responsibilities appears routine: assisting with catheters for residents who cannot remain still or administering medication when nurses are unavailable.

Cleaning, formally outside nursing assistance, is frequently absorbed into care work when no separate staff is hired. A former employee recalls that nursing assistants handled cleaning tasks as well. Grooming tasks further illustrate this expansion of roles. One care worker describes trimming residents' nails and hair herself when families refuse to pay for a hairdresser, explaining that she "can't just look at them with their hair like that, when everything else is taken care of." Professional differentiation between medical, domestic, and relational tasks becomes secondary to the immediate needs of residents. Importantly, workers do not describe this versatility as an additional competence but as an ordinary expectation of the job.

The physical dimension of this work reinforces its improvisational character. "This is a profession where you need to be versatile [polyvalent]," said one of our respondents. Care workers describe situations in which formal task allocation gives way to practical necessity. One recounts the case of a resident weighing around 130 kilograms who had been immobilised for months: Mobilisation depended not on formal roles, but on who was physically able to assist at that moment: "If I lift her with him, I very easily…she walks…but the girls can't lift her." In such situations, cooperation becomes essential. The distribution of tasks is shaped by bodily strength, availability, and experience rather than regulatory demarcation or formal planning.

Working conditions are further marked by staff shortages and institutional fragility. Care workers report staying beyond paid hours, covering for absent colleagues, and struggling to organise breaks or holidays because no replacement personnel is available. Care work appears as an accumulation of responsibilities produced by structural gaps—like staffing shortages and limited financial resources—without corresponding recognition in status, pay, or formal authority. Professional practice, therefore, develops through necessity and adaptation to patients' needs, rather than through clearly defined occupational differentiation with other professional roles in the nursing homes. Professional position lines are further blurred by the process of becoming qualified for different aspects of the job.

5.3. Professional Competence Between Formal Qualification and Tacit Knowledge

While qualification and formal training have traditionally been understood as central mechanisms through which professional groups distinguish themselves from other occupations, establish recognised expertise, and formalise professional boundaries, professional competence in care work cannot be reduced to formal qualifications alone but often develops through situated, embodied, and relational forms of learning. The experiences of care workers in Romanian nursing homes suggest that the relationship between certification and competence is neither linear nor stable. Professional competence often develops through multiple and uneven pathways, including informal, embodied, and practice-based learning processes that only partially overlap with formal training systems.

Many care workers describe entering the profession without formal qualifications and acquiring skills gradually, through colleagues, digital resources, and learning by doing. One former employee who entered the sector without certification explained that she was initially hired under a cleaning contract: "At first, they hired me based on the idea that experience wasn't mandatory….Initially, they hired me for cleaning services. Until I managed to complete the courses and obtain my nursing assistant diploma." Hiring people without certificates in positions that do not require formal qualifications—while expecting them to perform the work of a medical assistant or care worker—was a common strategy mentioned by both care workers and managers. Formal qualifications were frequently acquired later, through sporadic courses alongside employment.

While formal training opportunities do exist, they are partial and uneven. Some care workers completed medical assistant courses, sometimes while already employed. Others describe more intensive experiences, such as a two-year palliative care course that included several 3- or 4-day intensive workshops. Despite these occasional training courses and certifications, workers tend to emphasise experience as their main learning route. As one care worker with over seven years of experience in a nursing home said: "Here I took a qualification course to become a nursing assistant, but no…believe me, the best course is life." Training, therefore, is not the starting point of competence but an added layer of knowledge alongside continuous practice.

Informal learning emerges as a key mechanism through which tacit knowledge is formed and circulated. Techniques are transmitted horizontally, through peer guidance and demonstration, combined with YouTube videos and learning by doing. "Honestly, at first, I learnt from my colleagues over there—they showed me how to do things. Then I also took the course, read a bit, and watched things here too. So, I can say I learnt by working," noted one of the care workers, emphasising self-learning and peer skill transmission. One of the more experienced care workers recounted passing on skills to junior colleagues on a regular basis: "I also

watched some videos on YouTube…and she explained some lifting techniques to us….I teach the girls. Don't pull, don't strain yourself….You count '1–2-3' and then start." In this sense, learning happens bottom-up and in an unstructured fashion, based on needs, rather than established curricula.

Mutual assistance and informal task coordination fill the gaps left by formal training and qualifications. Heavy lifting, one of the most frequently mentioned examples across interviews, often becomes a collective task that care workers coordinate among themselves or require the assistance of other employees on the premises: "I always have to ask the cleaning lady or the physiotherapist or the nurse to help me put him in the chair and take him to the shower," explained one of our interviewees, reflecting a recurring pattern across respondents. These statements show that formal job categories dissolve under physical pressure. Cooperation across different categories of employees is considered indispensable, compensating for institutional gaps and creating collective forms of practical knowledge-sharing.

The availability and use of equipment is another point that care workers mention in the context of training. "There's no lifting system…or there is, but no one uses it or knows how," says one, adding: "No training is provided. No one wants to work with it. It's not mandatory…everyone's gotten used to their way." Learning how and using the equipment is an individual act. It is not introduced by the nursing home as a qualification and a required skill, despite its potential to improve working conditions. Thus, even where equipment is available, its effective use depends less on formal instruction than on embodied familiarity and confidence developed through repeated use. As studies of practical expertise suggest, the capacity to "know how" to act in concrete situations often exceeds what can be specified in manuals or procedural guidelines, which is at the core of tacit knowledge.

Taken together, these forms of learning correspond to what we conceptualised above as tacit knowledge: Skills are developed through observation, repetition, peer guidance, and gradual attunement to concrete situations rather than through formal instruction alone. Competence accumulates relationally. Because such competence is only partially visible within credential-based systems, professional boundaries remain blurred and differentiation between care roles remains weak.

5.4. Emotional Labour as Professional Competence

Emotional labour appears as the defining core of the job, not as an additional layer. Care workers consistently frame their work in relational and moral terms, describing attachment, patience, and empathy as more important than formal qualifications. As discussed in the literature section, emotional labour is not an individual disposition; rather, it becomes visible as part of how professional competence itself is understood and evaluated, yet is still not fully recognised as a professional category or as part of the formal job description.

Care workers describe their way of working as "from the heart" or "putting your soul into it," without being specifically asked or prompted to talk about this during the interviews. "If you don't do it from the heart, you can't be here. You need to have a heart and dedication," one points out, while another talks of the soul: "If you don't also put a bit of your soul into it, you're not meant to be here." Dedication comes up in other interviews too: "This work means sacrifice, first of all. And it means dedication." And in some cases, the language becomes explicitly familial: "Simply, they are our children." Caring is framed as a moral and, to some

extent, even familial obligation, rather than simply a job. Care workers build strong bonds with the residents over time. The capacity to connect, to reassure, and to demonstrate empathy is part of doing the job well, according to our respondents. This relational orientation echoes the discussion above on tacit knowledge: Understanding residents' needs is described as developing through proximity, accumulated familiarity, and everyday interaction rather than through formal instruction alone. Across interviews, emotional engagement repeatedly appeared as a requirement for doing care work properly rather than as an optional personal quality.

At the same time, this moral framing coexists with the material and structural pressures described earlier. The emotional commitment that respondents include as a job characteristic does not replace the physical demands of lifting, cleaning, assisting with medical procedures, or administering medication. It is layered onto them. The same workers who "work from the heart" are those who cut hair when families refuse to pay for a hairdresser, who step in when nurses are not available, and who work beyond their shifts because no replacement is available. Emotional labour thus operates both as a professional ideal and as a coping mechanism in under-resourced environments. It sustains meaning in conditions of overload and blurred boundaries, but it also risks normalising the expectation that care should exceed formal obligation. Emotional attachment is not formally recognised or remunerated, yet it becomes central to how workers understand their own professional value. As outlined in the literature section, emotional labour remains difficult to formalise, measure, and reward. The accounts above suggest that emotional engagement functions simultaneously as a source of professional meaning and as a mechanism through which additional responsibilities become absorbed into everyday care work without corresponding recognition.

Importantly, care workers themselves differentiate between what is formally expected of them and what they provide beyond these expectations. The expected tasks are clear: feeding, washing, mobilising, administering medication, and cleaning. Emotional support, by contrast, is described as something additional, something that depends on the individual. One woman explains that, if her own mother required more assistance, she would never consider a nursing home: "Who knows how they will treat her?" The fear she expressed was not about incorrect procedures, but about the indifference that can come from a care worker who is not emotionally involved with their patients. The implication is that affection is not guaranteed by the institution. Workers, therefore, frame their own emotional involvement as an exceptional contribution. In doing so, they implicitly construct a distinction between professional duty and moral surplus. Respondents consider emotional labour both central and a special skill that some of them bring to the job, rather than a requirement. As the next section demonstrates, this understanding is in direct tension with managerial discourses, in which emotional disposition is treated less as an additional contribution and more as a condition for employability itself.

6. Managers' Perspectives: Professionalisation Under Constraint

In the interviews with managers, the professional role of care workers appears as something shaped by institutional constraints and external conditions like labour shortage, and not by formal definitions required by the authorities. While legislation defines categories such as nurse, carer, or social worker, managers describe everyday practice as organised around availability, financial viability, and the ability to respond to residents' needs. Their accounts reveal how the role of the carer is negotiated between regulation, labour shortages, and the expectation that care must be both technically adequate and emotionally meaningful. In contrast to care workers, who described competence through everyday practice and accumulated

responsibilities, managers frame professionalisation primarily as an organisational challenge. Across all themes discussed below, categories, practices, qualifications, and emotional engagement are interpreted through the constraints of staffing, budgets, and institutional sustainability.

6.1. Categories and Professional Boundaries

The main aspects that keep recurring in the managers' accounts are financial limitations, which managers describe as the main reason for labour shortages, limited differentiation between professional categories, fast turnover, and restricted training opportunities. Differentiation between professional categories is only partially achieved due to resource constraints. One manager notes that the state subsidy of around RON 2,000 (approximately EUR 400) per beneficiary "doesn't even cover meals, let alone all necessary conditions." At the same time, the rates that families pay cannot be increased endlessly, because services would become unaffordable. Under these conditions, the expectation that each professional category is represented by a distinct staff member is seen as difficult to implement. "If we were to hire a person for every single position, we would end up having more staff than beneficiaries," notes one manager. Another explained: "We try to hire enough staff to cover, right? Right now, we have 50 employees for 68 elderly residents, but we cannot survive financially like this." Managers thus frame personnel arrangements primarily through what is feasible from an organisational perspective, rather than through formal definitions and requirements.

6.2. Practice, Infrastructure, and Everyday Adaptation

From the managers' perspective, the legal distinction between nurses and carers is clear, especially regarding medical responsibilities such as medication administration. Nonetheless, this strict separation is not implemented in daily practice. There is a tension between formal regulation, which assigns medical authority to nurses, and everyday practice, where carers become the primary actors. Legally, professional hierarchy exists. But on the ground, there is a strong overlap between roles. "Nurses and carers mostly perform similar tasks here," explains one of the managers—while recognising straight after that this should not be the case in theory—yet they lack the funds to hire more nurses. The role of the care worker expands beyond narrowly defined tasks, particularly in settings where staffing levels are limited.

Caregivers are described as the constant presence in residents' lives: "The caregiver is the one changing, dressing, feeding…hugging them, knowing their pain….For any issue, the elderly always go to the carer first, because they are the ones always available." While workers described this overlap as part of everyday care practice, managers ascribe it to institutional constraints and funding limitations.

Managers also emphasise that one of the main challenges of everyday care practice is its physical intensity. Since care work is performed predominantly by women, workers are nevertheless expected to carry out physically demanding tasks involving lifting, repositioning, bathing, and constant bodily support. Carers could be supported in these tasks by equipment and infrastructure, such as adjustable beds. Such equipment is not always available nor financially viable to maintain and expand, however. The quality of care depends on material conditions and, when these are limited, it falls to caregivers to compensate for such absences through their own labour. In contrast to workers, who emphasised practical adaptation and cooperation, managers frame this flexibility primarily as a response to financial and infrastructural limitations.

6.3. Qualifications, Training, and Retention

Another problem highlighted by the managers is the labour shortage and persistent difficulties in recruiting and retaining staff: "You must have specialised personnel. The problem is that it's very difficult to find people willing to work in this field." Labour shortages are linked both to the demanding nature of the work and to broader labour market dynamics. In some cases, negative working conditions in certain institutions lead employees to move "from one place to another." Better pay in state hospitals and widespread labour migration attract care workers elsewhere. As a result, institutions rely on individuals with limited formal preparation, invest in training that may not secure retention, and operate within a labour market where mobility is high.

Managers repeatedly emphasise that most caregivers do not enter the field with formal qualifications: "Most of them don't have any diploma. They are people with little formal education, so to speak, and we can only employ them as caregivers." Even when nursing aide courses are completed, their content is considered insufficient: "It's useless for us to expect a nursing aide to have medical knowledge, because they will never have it." Specialised training in elderly care is described as nominal: "This specialised job of elderly caregiver…to be trained specifically for elderly care, I don't think that exists. Or—you know how it exists? On paper. You pay, and the course is done, that's it." In this sense, certification exists, but the extent to which it is in-depth and useful is questionable. Institutions attempt to compensate by offering internal training opportunities. Caregivers are encouraged to complete nursing aide courses, yet role differentiation does not necessarily follow: "For the most part, the care assistant does the same work as the caregiver, at least here in our centre." Moreover, once qualified, employees often leave. Managers refer to movement toward public hospitals, where salaries increased significantly after reforms, as well as migration abroad: "We offer them the possibility to take the nursing aide course, they stay a few months, and then they leave further abroad." Professionalisation, in this context, produces mobility and a faster turnover, rather than stability. Unlike workers, who framed learning as accumulated practical competence, managers emphasise the difficulty of translating qualifications into stable professional roles.

6.4. Emotional Labour and the Limits of Professional Recognition

Care workers described emotional labour as central to good care but understood it as something contributed beyond formal expectations: an additional form of commitment grounded in attachment, empathy, and responsibility. Managers, on the other hand, recognise the same importance of emotional engagement but frame it differently: Emotional labour is described as part of being a professional carer. Managers repeatedly describe care work as requiring emotional engagement. One manager reflects: "You can come for an inspection and find all the papers in order, everything is fine, but what is missing is the feeling like home." Another states: "There are some who do it for money and others who do it from the heart and, without heart, a residential care centre cannot be sustained." Similarly to how care workers talk about their work, managers also underline that emotional labour is not treated as separate from professionalism but as integral to it. It is framed as what ensures that a nursing home functions beyond simply formal compliance.

These aspects of care work cannot be replaced by equipment or digital tools, according to one of the interviewed managers. When asked about digitalisation, he responds: "What could you digitalise? Emotion, love, washing, personal care?" At the same time, it is exactly these aspects of care work that are not codified as professional qualities or recognised as a special skill. While the embodied and relational character of care is presented as

resistant to technological substitution, actual recognition remains the purview of informal discussions, and its status as professional competence remains weakly formalised and institutionally unsupported.

Moreover, in three of the managers' interviews, it became apparent that emotional engagement is simultaneously recognised as indispensable and treated as personal disposition rather than labour requiring organisational support. Unlike care workers, who framed emotional engagement as something offered in addition to formal duties, the managers we interviewed increasingly described it as a precondition to being suitable for care work in the first place. Emotional engagement thus shifts from an additional contribution to an expected professional disposition. Through such processes of misrecognition, this moral investment becomes detached from its material value and framed as vocation, dedication, or personal suitability—rather than as the labour that keeps the institution functional.

7. Conclusion

This article asked what forms of professionalisation can be identified in care work in Romanian nursing homes and what institutional and organisational conditions shape and constrain this process. Our findings show that professionalisation processes are unfolding but are uneven and partial. Rather than emerging through formal qualifications, stable occupational boundaries, or coordinated institutional reform, professional roles develop largely from below through everyday adaptation, informal learning, emotional engagement, and practical knowledge accumulated in care practice.

Across both care workers' and managers' accounts, four interconnected dynamics became visible. First, formal occupational categories remain only weakly differentiated in everyday work, with boundaries between care, nursing, domestic, and emotional tasks continuously overlapping. Second, formal qualifications function as only one pathway into care work and often follow, rather than precede, practical involvement in care. Third, competence develops substantially through tacit and experience-based learning, transmitted horizontally through observation, repetition, cooperation, and problem-solving in concrete situations. Finally, emotional labour emerged as one of its central organising principles, framed differently by care workers and managers.

Our analysis demonstrates that emotional labour and tacit knowledge are not peripheral elements of care work but core professional resources that sustain residential care under conditions of labour shortages, institutional fragility, and weak role differentiation. Yet these competences remain difficult to formalise and are rarely translated into professional status, remuneration, or institutional recognition.

The comparison between workers' and managers' perspectives further demonstrates that professionalisation is understood differently depending on position within the institution. Care workers describe professional competence as accumulated through practice and often frame emotional engagement as something offered beyond formal expectations, but crucial for doing the job well. Managers, by contrast, tend to interpret competence through organisational sustainability, staffing constraints, and employability. Emotional engagement becomes indispensable while simultaneously being reframed as a personal disposition, rather than a recognised labour skill. Professionalisation, therefore, appears not as a coherent professional project but as an uneven and negotiated process shaped by institutional constraints and everyday adaptation.

The Romanian case offers a particularly revealing setting for examining these dynamics. In a context where care for older persons remains predominantly organised within families—and alternative forms of formal state-supported care remain weakly developed—nursing homes are among the few institutional spaces in which care workers are visible as a professional category. At the same time, because state provision remains limited and residential care is dominated by private providers, private nursing homes become the main arena where processes of care work professionalisation can currently be observed. This makes Romanian residential care analytically valuable, showing a process in the making with open-ended outcomes.

At the same time, this specificity also defines the limits of our study. By focusing only on private nursing homes in one economically stronger region, we do not capture other existing and emerging forms of elder care provision or claim representativeness for Romanian LTC as a whole. Instead, we deliberately set ourselves a narrower analytical task: to examine how professionalisation is negotiated in one institutional setting where care work becomes formalised, visible, and organised through paid labour. Within these limits, the study demonstrates that professionalisation in residential care is neither absent nor linear but emerges through everyday practice. Professionalisation in Romanian residential care, therefore, appears less as an accomplished institutional project than as an ongoing process sustained by workers' everyday expertise, yet only partially recognised within the structures that depend on it. Future research should extend this analysis to other forms of care provision and explore how different institutional arrangements shape the recognition and organisation of care work.

Acknowledgments

This article was produced as part of the project Researching the Transnational Organization of Senior Care, Labour and Mobility in Central and Eastern Europe (CareOrg, 2023–2026; https://careorg.eu), funded by the Volkswagen Foundation within the programme "Challenges and Potentials for Europe." We would like to thank the research assistants who supported us with the empirical data collection: Dana Solonean, Cătălina Codiță, Mária-Magdolna Lukacs. Special thank you goes to Anca Simionca for the valuable feedback, as always.

Funding

Publication of this article in open access was made possible through the institutional membership agreement between Babeș-Bolyai University and Cogitatio Press.

Conflict of Interests

The authors declare no conflict of interest.

Data Availability

The data are not available for public use.

LLMs Disclosure

During the preparation of this work, the authors used Claude (Sonnet 5, Anthropic) to assist with reference formatting and language editing. After using this tool, the authors reviewed and edited the output as needed and take full responsibility for the content of the publication.

References

Abbott, A. (1988). *The system of professions: An essay on the division of expert labor*. University of Chicago Press.

Bellini, A., & Maestripieri, L. (2023). Introduction: Within, between, beyond—A multi-dimensional approach to the study of professionalism and social change. In L. Maestripieri & A. Bellini (Eds.), *Professionalism and social change* (pp. 1–35). Palgrave Macmillan. https://doi.org/10.1007/978-3-031-31278-6_1

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Addison-Wesley.

Bó, B., Zimmer, Z., & Rada, C. (2020). The structure and determinants of intergenerational support exchange flows in an Eastern European setting. *Research on Aging*, *42*(9/10), 262–271. https://doi.org/10.1177/0164027520920026

Bolton, S. C. (2005). *Emotion management in the workplace*. Palgrave Macmillan.

Buletin de București. (2023, January 25). *Egalitatea de șanse gestionată din Guvern de „Sfânta Gabriela cea Vitează," business de aur pe bani publici pentru apropiații ei*. https://buletin.de/bucuresti/egalitatea-de-sanse-gestionata-din-guvern-de-sfanta-gabriela-cea-viteaza-business-de-aur-pe-bani-publici-pentru-apropiatii-ei

Daly, M., & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *British Journal of Sociology*, *51*(2), 281–298.

Dohotariu, A., & Băluță, I. (2021). Care in post-socialist Romania: Between gendered regulations, silencing and political concerns. *The Romanian Journal of Society and Politics*, *15*(2), 20–50.

England, P. (2005). Emerging theories of care work. *Annual Review of Sociology*, *31*, 381–399.

European Commission. (2021). *Long-term care report: Trends, challenges and opportunities in an ageing society. Volume II: Country profiles*. https://doi.org/10.2767/677726

European Commission. (2022). *Study on the long-term care supply and market in EU Member States—Final report*. https://data.europa.eu/doi/10.2767/814178

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current Sociology*, *59*(4), 406–422.

Evetts, J. (2014). Professionalism: Theoretical changes and challenges. *Travail, Emploi, Formation*, *11*, 90-110.

Folbre, N. (2001). *The invisible heart: Economics and family values*. The New Press.

Ghența, M., & Matei, A. (2024). Changes under pressure: Mapping recent developments in long-term care policy. *Transylvanian Review of Administrative Sciences*, *72E*, 21–39. https://doi.org/10.24193/tras.72E.2

Hărăguș, M., & Földes, I. (2026). Care under constraint: Unmet care needs among older adults in Romania. *Social Inclusion*, 14, Article 12028. https://doi.org/10.17645/si.12028

Hochschild, A. R. (1983). *The managed heart: Commercialization of human feeling*. University of California Press.

Hochschild, A. R. (2015). Global care chains and emotional surplus value. In *Justice, politics, and the family* (pp. 249–261). Routledge.

Inglot, T., Szikra, D., & Raț, C. (2022). *Mothers, families, or children? Family policy in Poland, Hungary, and Romania, 1945–2020*. University of Pittsburgh Press.

Johnson, E. K. (2015). The business of care: The moral labour of care workers. *Sociology of Health & Illness*, *37*(1), 112–126.

Larson, M. S. (1977). *The rise of professionalism: A sociological analysis*. University of California Press.

Leitner, S. (2003). Varieties of familialism: The caring function of the family in comparative perspective. *European Societies*, *5*(4), 353–375. https://doi.org/10.1080/1461669032000127642

Meagher, G., & Szebehely, M. (2013). Long-term care in Sweden: Trends, actors and consequences. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe* (pp. 55–78). Springer.

Ministry of Labor, Family, Youth and Social Solidarity. (2026). *Single electronic register of social services*. https://mmuncii.gov.ro/acreditare-furnizori-si-servicii-sociale

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. Routledge.

Mol, A., Moser, I., & Pols, J. (2010). Care: Putting practice into theory. In A. Mol, I. Moser, & J. Pols (Eds.), *Care in practice: On tinkering in clinics, homes and farms* (pp. 7–26). transcript.

Palenga-Möllenbeck, E. (2013). Care chains in Eastern and Central Europe: Male and female domestic work at the intersections of gender, class, and ethnicity. *Journal of Immigrant & Refugee Studies*, *11*(4), 364–383. https://doi.org/10.1080/15562948.2013.822955

Polanyi, M. (1966). *The tacit dimension*. University of Chicago Press.

Precupetu, I., Aartsen, M., & Vasile, M. (2019). Social exclusion and mental wellbeing in older Romanians. *Social Inclusion*, *7*(3), 4–16. https://doi.org/10.17645/si.v7i3.2008

Razavi, S. (2007). *The political and social economy of care in a development context: Conceptual issues, research questions and policy options* (Working Paper No. 3). United Nations Research Institute for Social Development.

Reinders, H. (2010). The importance of tacit knowledge in practices of care. *Journal of Intellectual Disability Research*, *54*, 28–37. https://doi.org/10.1111/j.1365-2788.2009.01235.x

Riley, R., & Weiss, M. C. (2016). A qualitative thematic review: Emotional labour in healthcare settings. *Journal of Advanced Nursing*, *72*(1), 6–17. https://doi.org/10.1111/jan.12738

Saraceno, C., & Keck, W. (2010). Can we identify intergenerational policy regimes in Europe? *European Societies*, *12*(5), 675–696. https://doi.org/10.1080/14616696.2010.483006

Theodosius, C. (2008). *Emotional labour in health care: The unmanaged heart of nursing*. Routledge.

Tholen, G. (2017). Symbolic closure: Towards a renewed sociological perspective on the relationship between higher education, credentials and the graduate labour market. *Sociology*, *51*(5), 1067–1083. https://doi.org/10.1177/0038038516641857

van Hooren, F. J. (2012). Varieties of migrant care work: Comparing patterns of migrant labour in social care. *Journal of European Social Policy*, *22*(2), 133–147. https://doi.org/10.1177/0958928711433654

van Hooren, F. J., Apitzsch, B., & Ledoux, C. (2019). The politics of care work and migration. In A. Weinar, S. Bonjour, & L. Zhyznomirska (Eds.), *The Routledge handbook of the politics of migration in Europe* (pp. 363–373). Routledge. https://doi.org/10.4324/9781315512853-34

World Bank. (2022). *Studiu de fundamentare pentru elaborarea Strategiei de îngrijire pe termen lung 2023–2030 și potențialele reforme ale cadrului legislativ care guvernează asistența socială pentru persoanele vârstnice*. https://mmuncii.gov.ro/wp-content/uploads/2025/08/2022_Studiu_de_fundamentare_pentru_elaborarea_Strategiei_ILDIA_2023-2030_RO-2.pdf

Wrede, S., Henriksson, L., Høst, H., Johansson, S., & Dybbroe, B. (Eds.). (2008). *Care work in crisis: Reclaiming the Nordic ethos of care*. Studentlitteratur.

About the Authors



Neda Deneva (PhD) is a senior researcher at the Department of Sociology, Babeș-Bolyai University in Cluj-Napoca, Romania. Her research explores care work, labour transformations, migration, citizenship, and welfare, examining how mobility and social inequalities reshape work, families, and state–society relations in Central and Eastern Europe.



Ionuț Földes (PhD) is a lecturer in demography, statistics, and family sociology at the Faculty of Sociology and Social Work, Babeș-Bolyai University in Cluj-Napoca. His research interests include demography and population sociology, social inequalities in ageing and care, intergenerational relationships, family dynamics, implications of migration for well-being, and support across generations.



Denisa Ursu is a PhD student at the Faculty of Sociology and Social Work, Babeș-Bolyai University in Cluj-Napoca, Romania. Her research interests include migration, reproductive labour, the commodification of care, transnational families, care drain, and the circulation of care in the context of ageing.



Mihaela Hărăguș (PhD) is a researcher at the Centre for Population Studies, Babeș-Bolyai University in Cluj-Napoca, Romania. Her research interests include intergenerational relations in families in general, and in transnational families in particular, as well as the challenges of population ageing for the development of long-term care.

Social Inclusion
2026 • Volume 14 • Article 12375
https://doi.org/10.17645/si.12375

cogitatio

ARTICLE

Open Access Journal

The Limits of State Control in Regulating Live-In Care Work in The Netherlands

Siënna Hernandez [1], Kristína Bartošová [2], and Franca van Hooren [3]

[1] Institute of Social and Cultural Anthropology, Leipzig University, Germany
[2] Faculty of Humanities, Charles University, Czech Republic
[3] Political Science Department, University of Amsterdam, The Netherlands

Correspondence: Franca van Hooren (f.j.vanhooren@uva.nl)

Submitted: 12 March 2026 **Accepted:** 17 June 2026 **Published:** 23 July 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Across Europe, migrant live-in care workers from Central and Eastern Europe play an increasingly important role in long-term care systems. These arrangements are often associated with precarious working conditions, including long hours, low pay, and blurred boundaries between work and private life. The Netherlands is sometimes considered an exception, as generous cash-for-care subsidies combined with relatively strict regulation suggest that live-in care workers should be protected from such conditions. Yet reports of exploitation continue to emerge. This article examines how precarious working conditions persist despite extensive regulation. Drawing on a qualitative study of Slovak migrant live-in care workers and intermediaries operating between Slovakia and the Netherlands, the analysis explores how care arrangements are organised and governed in practice. The findings show that formal compliance with labour regulations often coexists with expectations of near-constant availability. Intermediaries play a central role in structuring these arrangements, shaping recruitment, contracts, and mobility between households and workers. Using a framework that examines the interaction between funding, regulation, information, and enforcement in welfare markets, the article demonstrates how generous public funding and strong regulation can still produce regulatory blind spots. By focusing on the everyday experiences of migrant workers and the role of intermediaries, the study contributes to debates on the governance of migrant care labour and the regulation of household-based care markets.

Keywords

cash-for-care; labour regulation; live-in care; migrant care workers; welfare markets

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

Across Europe, migrant live-in care workers from Central and Eastern Europe have become central to the provision of care for older people. In countries such as Italy, Austria, and Germany, they are structurally embedded in household-based care arrangements, often under ambiguous employment and residency conditions (Aulenbacher et al., 2024; Da Roit & Le Bihan, 2010; Trukeschitz et al., 2022). These arrangements are closely linked to the marketization of care (Farris & Marchetti, 2017; Hoppania et al., 2024) through cash-for-care schemes that allow families to organise care themselves by combining public benefits with private resources (Da Roit & Le Bihan, 2010; Ungerson & Yeandle, 2007). Research has consistently shown that live-in care work financed through cash-for-care schemes tends to entail precarious working conditions, including long hours, low pay, informal employment, and blurred boundaries between work and private life (Boccagni, 2017; Gábriel, 2020; Lutz & Palenga-Möllenbeck, 2010). Even in countries that have introduced specific regulations for migrant live-in care, these problems persist (Österle & Bauer, 2016; Sagmeister, 2024).

The Dutch system is sometimes presented as an exception within the European migrant care landscape. Alongside elaborate in-kind care provision, the Dutch cash-for-care subsidy is highly generous and more strictly regulated than in other countries. Previous research has suggested that, as a consequence, live-in migrant care workers receive at least the Dutch minimum wage and work within regulated hours (Böcker et al., 2021; Da Roit & Van Bochove, 2017). Yet journalistic investigations and our own fieldwork point to a more ambiguous reality. Reports describe workers who, on paper, work 40 hours, but in reality work day and night (Van Wanroij, 2024, 2025a, 2025b). How can such exploitative conditions persist despite a generous funding scheme and extensive regulation?

The dynamics of care marketization in practice are shaped by concrete policy choices (Farris & Marchetti, 2017; Hoppania et al., 2024; Ledoux et al., 2021; Shutes & Chiatti, 2012; Van Hooren, 2012). Building on Ledoux et al.'s (2021) three-dimensional typology of policy instruments, which highlights the role of funding, regulation and information in shaping welfare markets, we add a fourth dimension: enforcement, understood as the state's capacity to ensure that welfare market regulations are effectively implemented. Empirically, our analysis focuses on a case study of Slovak live-in care work in the Netherlands and draws on policy analysis, observations, and interviews with Slovak care workers, Slovak and Dutch intermediary agencies and Dutch regulators. We show that precariousness in live-in migrant care is both a consequence of weak enforcement and a systemic outcome of how states design and govern welfare markets. In this context, intermediary agencies can become active producers of semi-formal practices, using legal and organizational workarounds such as self-employment and sub-contracting to reconcile formal compliance with low wages and expectations of near-constant availability from care workers.

Hereafter, we situate live-in migrant care work within broader debates on welfare markets, outlining how financial, regulatory, informational, and enforcement instruments interact with the role of intermediary agencies and migrant care workers. Section 3 presents our research design and methods, detailing the multi-sited ethnographic approach connecting fieldwork in Slovakia and the Netherlands. Section 4 maps the Dutch policy instruments that govern live-in care, while Section 5 analyses how Slovak live-in care workers and Slovak and Dutch agencies navigate this institutional landscape in practice. In Section 6, we show how a lack of information and enforcement capacity limits Dutch state control of live-in migrant care

work. The conclusion draws out the broader implications for understanding the limits of state control in welfare markets and reflects on possible avenues for improving the regulation and protection of live-in migrant care workers.

2. Dynamics of Welfare Markets and Live-In Migrant Care Work in Europe

European long-term care systems are increasingly characterised by marketization, that is, the expansion of market mechanisms and consumer choice into domains previously dominated by public or family provision (Farris & Marchetti, 2017). This development has given rise to "welfare markets" (Ledoux et al., 2021), in which care is organised through complex interactions between state funding, private providers, and household demand, often across borders (Shutes & Chiatti, 2012; Van Hooren, 2012). Within these markets, live-in care has become a key organizational form, sustained by transnational intermediaries, subcontracting chains and organizational models designed to maximise flexibility, minimise statutory labour obligations, and diffuse responsibility for working conditions (Aulenbacher et al., 2024; Hoppania et al., 2024; Lutz & Palenga-Möllenbeck, 2010). Rather than emerging solely from regulatory gaps, the precariousness of live-in care is thus actively enabled by the institutional design of welfare markets themselves.

The conditions under which migrant live-in care workers are employed are closely shaped by policy instruments. In this article, we distinguish four key types of policy instruments. We apply Ledoux et al.'s (2021) three-dimensional typology of financial, regulatory, and informational policy instruments to the field of live-in care, adding a fourth dimension: enforcement, by which we mean the ability to monitor and enforce compliance. Hereafter, we elaborate on each of these instruments and how they shape live-in care work. Later, in section four below, we discuss each of these policy instruments in more detail in the Dutch context.

Financial instruments (most notably cash-for-care schemes) provide people in need of care with the financial means to organize care themselves (Da Roit & Le Bihan, 2010; Ungerson & Yeandle, 2007; Van Hooren, 2012). These schemes, now widespread in Europe, vary greatly in their generosity, from modest flat-rate benefits to highly substantial and graded subsidies. By allowing households to combine public subsidies with private resources, cash-for-care schemes create demand for live-in arrangements that would otherwise be unaffordable, thereby stimulating the recruitment of cheap migrant workers under flexible and often precarious conditions (Shutes & Chiatti, 2012; Van Hooren, 2012)

Cash-for-care benefits differ not only in their generosity but also in how strictly their use is regulated, ranging from complete freedom to tight rules on service organization and quality requirements (Da Roit & Le Bihan, 2010; Ungerson & Yeandle, 2007; Van Hooren, 2012). Other regulatory instruments include labour standards, collective agreements, migration regulations, and social protection rules. Where spending of cash-for-care benefits is unregulated, as in Italy or Germany, recipients often use subsidies to finance informal or irregular care arrangements, which are characterised by long hours, low pay and the absence of social protection (Gábriel, 2020; Lutz & Palenga-Möllenbeck, 2010; Van Hooren, 2012). In response, some countries have introduced tightened or supplemented regulations. For example, in 2007 Austria introduced a regulated supplement to its unregulated cash-for-care subsidy (Österle & Bauer, 2016; Schmidt et al., 2016). This means-tested supplement is conditional on formal engagement, through employment or based on a contract with a self-employed care worker (Schmidt et al., 2016). In practice, most households in Austria choose to engage a self-employed worker. Such constructions are often used in live-in care work.

They have been called "bogus self-employment," because the reality of live-in care work implies "directing and supervising the working activity in a manner incompatible with the independent status of self-employment" (Sagmeister, 2024, p. 122). Consequently, despite attempts to regulate live-in care work, the sector continues to be governed through regulatory grey zones (Schmidt et al., 2016).

Informational and enforcement instruments further shape how welfare markets operate in practice. By informational instruments we mean registration systems, reporting requirements, and administrative categories. The information dimension of welfare markets is not neutral. It shapes what becomes visible and actionable in policy, regulation, and public debate. Having information on what happens within welfare markets is a crucial step towards formalizing care work and improving working conditions (Daly et al., 2025). While some countries, such as Austria, keep formal registries of (self-employed) live-in care workers or the agencies that offer these services (Sagmeister, 2025), in many other countries live-in care remains poorly captured in statistics and administrative registers and there is consequently little knowledge to inform policy debates (Leiber et al., 2019).

Finally, by instruments of enforcement, we mean public authorities that attempt to monitor and enforce the implementation of regulations. Compliance may be enforced by labour or healthcare inspections, or tax audits. Yet it is complicated by the fact that care is delivered in private households, where authorities cannot simply enter for inspections, and often remains invisible to authorities. As a consequence, the extent to which informal practices are controlled and punished remains limited (Seiffarth, 2023). Enforcement is further complicated by transnational subcontracting chains, which fragment responsibility across agencies and jurisdictions and allow states to tolerate widespread irregularities while formally upholding protective regulations (Aulenbacher et al., 2021). In Germany, for instance, the persistent lack of effective enforcement in live-in care has led scholars to describe the state as complicit in maintaining an informal market (Lutz & Palenga-Möllenbeck, 2010).

Together, these four policy dimensions shape the dynamics of welfare markets and the working conditions of live-in carers. A key group of actors within these markets is intermediary agencies. They connect care workers and recipients, organize recruitment and cross-border mobility, and often shape the contractual form of employment. While agencies can, in principle, contribute to the formalization of employment and strengthen workers' bargaining position (Fudge & Hobden, 2018; Lobel, 2001), research in the European context more often highlights their role in reproducing precarious labour relations. Agencies frequently rely on (bogus) self-employment or subcontracting, which shift the risks of sickness, unemployment, and fluctuating demand onto workers and weaken their capacity for collective organization (Steiner et al., 2020; Uhde, 2016; Uhde & Ezzeddine, 2020). Care workers thus navigate labour markets in which their formal status as self-employed entrepreneurs coexists with strong dependency on agencies for access to clients, information, and legal compliance.

3. Research Design and Methods

This study combines a mapping of Dutch policy instruments with qualitative multi-sited ethnographic research (Marcus, 1995) conducted in the Netherlands and Slovakia in the context of an international research project on transnational organization of senior care (https://careorg.eu). To trace how live-in care work is organized across Slovakia and the Netherlands, we approached live-in care as a transnational

arrangement in which migration decisions and recruitment processes largely originate in Slovakia, while working conditions are shaped through interactions with Dutch clients, agencies, and institutions within the context of the Dutch welfare state.

We mapped the regulatory framework governing live-in care in the Netherlands by analysing legislation and policy instruments related to long-term care and personal budgets. We also explored the Dutch live-in care sector through providers' websites and other publicly available materials. To examine the everyday organization of this welfare market, we conducted semi-structured interviews and observations with care workers, intermediaries, and institutional actors across both countries. Between June and September 2024, we carried out 18 interviews in Slovakia with 12 Slovak care workers and six intermediaries recruited through Facebook groups and snowball sampling. In these interviews, we focused on migration trajectories, work practices, temporal work arrangements, and the role of agencies in organising transnational care. Alongside interview data, we also analysed work-related and administrative documents shared by care workers, including contracts, schedules, and agency materials. These materials helped us better understand the bureaucratic and organizational dimensions of transnational live-in care. In the Netherlands, we conducted five interviews with representatives from three organizations providing live-in care, including one agency that specifically recruits and coordinates Slovak care workers. We also interviewed representatives of a sectoral association and a regional care office (*Zorgkantoor*), as well as a Slovak agency manager based in the Netherlands.

This article is based on a collaboration between Czech and Dutch researchers. Siënna Hernandez conducted most of the interviews in the Netherlands, Kristína Bartošová conducted most of the interviews in Slovakia, and Franca van Hooren was primarily responsible for the policy analysis. Some interviews in the Netherlands were conducted jointly. They were conducted in Slovak, English, German, and Dutch, depending on the preferences of the interviewees. Where possible, we audio-recorded and transcribed interviews and complemented them with detailed field notes. The transnational composition of the research team played a central role throughout the research process, particularly in connecting ethnographic insights from Slovakia with institutional and policy perspectives from the Netherlands.

4. Mapping Dutch Policy Instruments

This section presents the results of our policy analysis and maps Dutch welfare market policy instruments in relation to live-in care work. Distinguishing between instruments of financing, regulation, information, and enforcement, we show that generous funding and tight regulations coincide with limited information and scattered enforcement authority.

4.1. Financing

The Netherlands has a long history of relatively generous state funding of long-term care (Da Roit, 2018). Most funding is used to organize in-kind care services (including home care and residential care). People with permanent and intensive care needs are covered by the Long-Term Care Act, which provides either in-kind care or cash-for-care benefits. Care offices (*Zorgkantoren*) decide in consultation with the client whether care is provided in-kind or through a cash-for-care benefit (*PGB*/personal budget). The personal budget is managed by an administrative body (*Sociale Verzekeringsbank*/social insurance bank) and, notably different from other

states, it is not paid out to care recipients, but directly to the providers of care, i.e., either a care worker or a care providing agency.

The Dutch cash-for-care benefit for people with permanent and severe care needs is highly generous. It is paid at different levels, varying from EUR 4046 to EUR 8207 per month (in 2025), with the most frequently granted amount being EUR 5489/month. For comparison: Italy provides an unconditional flat-rate benefit of around EUR 550/month. Cash benefits under the German long-term care insurance range from approximately EUR 350 to EUR 1000 (Bundesministerium für Gesundheit, n.d.), and in Austria most recipients who need permanent care receive around EUR 1,175/month (Bundesministerium für Arbeit, n.d.). Despite its generosity, only approximately 8% of recipients of permanent and intensive long-term care in the Netherlands receive a cash benefit (the other 92% receive in-kind care; Ministerie van Volksgezondheid, 2025a). This is probably the result of the existence of good in-kind alternatives and the stringent regulations attached to the personal budget, to which we turn now.

4.2. Regulation

The Dutch personal budget comes with very strict regulations on how it can be spent. These rules, which are largely driven by concerns about fraud and misuse of welfare subsidies, have been tightened repeatedly in recent years (Böcker et al., 2021; Da Roit & Van Bochove, 2017). To provide care financed through a personal budget, care workers must have a formal contract which is approved by a regional care authority. In addition, since 2022, a new Care Providers Accreditation Act (WTZA) stipulates that all care providers (including those who are self-employed or directly employed by families) must be formally registered as a care provider (Ministerie van Volksgezondheid, 2025b). Registration is conditional upon quality control systems, client councils, and compliance procedures. There is also a licensing requirement for care providers with more than 10 care workers, which, however, does not apply to subcontractors or self-employed providers.

Meanwhile, the Netherlands does not have any specific regulations for live-in care work, nor does the collective labour agreement for the care sector cover live-in care. Care workers who work for more than three days a week for one household or employer fall under regular Dutch labour law standards (exceptions apply only to those who are employed by a household for less than three days a week; see Van Hooren, 2018). Labour standards include a minimum wage (14 EUR per hour in 2025), a maximum average work week of 48 hours, and regular work-free periods (at least 11 consecutive rest hours per 24 hours and 36 consecutive hours every seven days). Regulations for being on call (for example, during the night) stipulate that this is counted as working time if the (care) worker must remain on location (Burri et al., 2018). Moreover, a worker can be on call for no more than 14 nights per month.

While these pay and working time regulations do not apply in case of "genuine" self-employment (characterised by short-term assignments for multiple employers and autonomy to decide on working times and execution), bogus self-employment is suspected when the client (*opdrachtgever*) decides on working time and when pay is set at a regular rate per hour or day worked (Rijksoverheid, 2026a). Where bogus self-employment is established, general labour regulations apply. This also applies to self-employed workers who are posted from another EU country.

4.3. Information and Enforcement

While detailed statistics exist on care workers' activities in regular (live-out) home care and institutional care (CBS Statline, n.d.), there is no register nor survey data on live-in care work. There is data on the frequency of use of personal budgets, but no record is kept of who uses this budget to purchase live-in migrant care work, nor are there registers for providers of live-in care.

Meanwhile, a range of regulatory and enforcement agencies have responsibilities related to different aspects of personal budgets and care arrangements, yet none of them is directly concerned with live-in care work. Regional care offices check contracts between clients and care providers; the social insurance authority pays care providers; the health care inspectorate (*Inspectie Gezondheidszorg en Jeugd*) enforces quality standards; the labour inspectorate (the Netherlands Labour Authority) controls compliance with labour standards; and the tax authority fights bogus self-employment. In Section 6, we discuss how the lack of information and the scattered enforcement agencies limit Dutch state control over the live-in care market.

5. Dynamics of the Dutch Live-In Care Market

This section describes the results of our interviews and observations of the transnational dynamics of live-in care work in Slovakia and the Netherlands. We show that, as in other European countries (Aulenbacher et al., 2021, p. 12), the employment of live-in care workers operates through layered brokerage chains involving Slovak agencies and Dutch partners. We examine how these actors navigate Dutch regulations and show how Slovak care workers, Slovak agencies, and Dutch agencies jointly produce precarity despite stringent regulations.

5.1. Precarity Experienced by Slovak Live-In Care Workers in the Netherlands

Slovak care workers primarily enter the Dutch live-in care market because it offers higher earnings compared to Slovakia, a pattern widely observed among Central and Eastern European caregivers across Western Europe (Bahna & Sekulová, 2018; Bruquetas-Callejo, 2019). Many interviewed Slovak carers also emphasised independence and flexibility. Most are formally self-employed, contracted through Slovak intermediaries and posted to the Netherlands. They typically work rotational schedules of about six weeks in the Netherlands followed by a similar rest period in Slovakia, a pattern common in European live-in care systems (Leiblfinger et al., 2021).

Despite being formally self-employed, many interviewees report signing contracts that, in our view, resemble employment contracts, including agreements on a maximum of eight hours of work per day or a minimum of sixteen hours of weekly leisure time. Meanwhile, interviews reveal a clear mismatch between contractual representation and lived experience. In practice, working times are structured around the needs of the care recipient and are often longer or more unpredictable than is suggested in written contracts. Caregivers describe being woken repeatedly during the night and feeling unable to refuse requests for assistance, as care obligations extend beyond what would normally be considered protected sleep time. Mia (26) explains:

> He woke me up twice at night. I had to come…you can't just close the door…because you never know what will happen….When the call comes, you must come right away. You can't separate it or complain that you are tired.

Rozália (39) recalls never receiving a contract that clearly defined working hours or leave. As a result, she was never certain whether she was entitled to time off and had to negotiate this informally with the client's family. Such informal negotiation is typical in migrant live-in care work, where employment relations depend heavily on interpersonal arrangements (Shutes & Chiatti, 2012, p. 398). The issue concerns not only long working hours but also the fragmentation of "free time" into frequently interrupted breaks. Within this context, caregivers often describe "freedom" in spatial rather than contractual terms: Being free means physically leaving the house. This reflects a practical workaround to the absence of enforceable rest-time boundaries. Lujza (28) frames leaving the household as a temporary escape from a totalising work environment, explaining that she goes out "just to get out of the house, because it's all just work," a strategy documented among migrant domestic workers seeking limited autonomy outside the household (Fedyuk, 2020, p. 160). These experiences illustrate a key feature of live-in care: blurred boundaries between working time, on-call time, and personal time within private households (Ezzeddine & Matiaško, 2026, p. 7).

Rather than guaranteeing clear limits on working hours or rest periods, contracts often further constrain care workers' freedom. Vera, a self-employed worker contracted by a Slovak agency, showed us her contract, which framed care as a "business activity" and included financial penalties (for example, for not starting work [EUR 300], for leaving before a replacement was found [EUR 300], or for working directly with a client within twelve months [EUR 3,000]). Even mistreatment did not necessarily void these penalties, suggesting that the contract functioned more for disciplining exit than for protecting care providers, a mechanism also observed in other European live-in care markets (Aulenbacher et al., 2021, p. 14).

Remuneration of care workers is typically based on a daily rate and depends on the caregiver's qualifications as well as the severity of the care recipient's needs. In our fieldwork, reported pay ranged from EUR 60 to EUR 90 per day. In addition, some care workers receive a weekly allowance of up to EUR 70 for food. During a six-week work period, caregivers earn between EUR 2,500 and EUR 3,800. Since these six weeks of work are usually followed by six weeks without paid work, the effective monthly income ranges between approximately EUR 840 and EUR 1,260.

The work practices described by the Slovak care workers we interviewed suggest that their contractual engagement is a form of bogus self-employment, where workers formally operate as independent contractors but function as dependent employees (Leiblfinger et al., 2021, p. 497; Sagmeister, 2024). Meanwhile, the working conditions reported by the Slovak care workers do not comply with Dutch labour standards for dependent employees. While interviewees report working more than full time, the reported pay is much lower than Dutch minimum wage standards, EUR 112 for an 8-hour workday (in 2025). The described practices of being on call nearly all the time are not allowed according to Dutch working time regulations, which stipulate a minimum rest period of 11 hours per day and prescribe that a worker can only be on call for two weeks out of every four weeks.

However, the administrative arrangement of self-employment and posted work makes it difficult for Slovak care workers to identify who is accountable for their working conditions. This means they are dependent on

the enforcement of minimum standards by Dutch authorities, which, as we will show in more detail below, is also limited. Meanwhile, care workers' limited Dutch language skills further undermine their ability to negotiate working conditions, establish boundaries, and understand their rights. In the weakly formalised sector of home care, limited language competencies place migrant care workers in more vulnerable and dependent positions (Bahna, 2020; Fedyuk, 2020, p. 160; Gábriel, 2020). Agencies often do not provide systematic language training, meaning workers are dependent on self-study (Renáta, 34, coordinator).

5.2. Slovak Intermediaries Deliberately Constructing Precarious Work

Slovak brokering agencies operating in the Netherlands are typically small to medium-sized. They are privately owned and specialize in live-in care. They have a small administrative team, personalised coordination practices, and informal transnational networks rather than large corporate infrastructures. Agencies operate transnationally, often maintaining their main administrative base in Slovakia while collaborating closely with Dutch partner agencies that represent clients and families in the Netherlands. Slovak agencies thus play a key role in structuring employment relations and working conditions (Aulenbacher et al., 2021, p. 13) and play a central role in recruiting and coordinating caregivers for Dutch households. In Irena's (45, agency owner) description, "the Slovak agency recruits and employs the care workers, while Dutch agencies find the clients."

It is worth mentioning that several agencies encountered during our fieldwork were founded or managed by former care workers. This is noteworthy because live-in care work is often associated with limited opportunities for career development. Yet some care workers progress to management positions:

> I worked with tulips when I first arrived here [in the Netherlands]….At that time, my friend was working as a care worker for a Slovak agency in the Netherlands. So she pulled me in as a care worker for the company. And I gradually worked my way up from care worker to coordinator, from coordinator to manager….I started doing care work when I was 21 years old. (Milada, 45, manager)

For other care workers, their experiences provided them with the necessary expertise and transnational networks to start their own agency. As one Slovak agency owner explained, her previous care work for another agency provided her with contacts and practical know-how that could later be mobilised to establish her own agency (Irena, 45, Slovak agency owner).

The interviews with the agencies reveal that the reliance on self-employment arrangements is explicitly seen as flexible and administratively convenient. It is presented as an advantage that in this type of employment relationship, working conditions are difficult to contest. One coordinator summarised the contractual implications bluntly: "As self-employed workers, their hours aren't limited" (Hana, 48). The same coordinator acknowledges: "You are guaranteed 16 hours of free time per week, but those hours…you were basically on standby."

Meanwhile, many agency owners point to the risks involved in extended payment chains linking Dutch clients, cash-for-care allowances, Dutch agencies, and Slovak intermediaries. Irena (45) emphasises that this structure creates financial vulnerabilities for agencies as well as caregivers:

> There's always a risk involved, especially because I depend on payments from Dutch [agencies]….I've had the experience where a Dutch [agency] didn't pay, and unfortunately, I couldn't pay the care worker either….So, as a Slovak agency, we bear all the risk. The Dutch agencies are private businesses too; it's not state-run.

Such fragmented financial arrangements are typical of transnational care labour markets and expose migrant caregivers to delayed or missing remuneration (Leiblfinger et al., 2021, p. 498).

Slovak agencies are responsible for the recruitment of care workers. Their recruitment practices illustrate tensions between professional standards and labour shortages. As coordinator Renáta (34) explains, agencies "cannot afford qualified caregivers because they are too expensive." By choosing care workers with fewer formal qualifications, agencies can tailor the level and cost of care to their budget. In practice, economic pressures shape recruitment decisions. Coordinators recall moments when agencies could not afford to be selective, accepting "almost anyone" simply to fill gaps. According to Renáta, "in 90% of cases, we were just grateful that we had someone at all," while another coordinator remembers the misery of having to choose "between bad and worse." Growing demand and labour shortages thus encourage agencies to prioritise availability over qualifications.

Consequently, although agencies nominally mention requirements such as caregiving certificates, references, and language skills, these standards are frequently enforced more formally than substantively. Božena (40), an HR manager, describes the official requirement of an EU-accredited caregiving certificate:

> They need to have, for example, the Red Cross or an educational academy requires a certain number of hours of training, I think 280, or she must have medical school training, medical education…as long as she has the basics.

Yet care workers' accounts suggest that such formal requirements are not always met in practice.

5.3. Dutch Care Provider Agencies Formalising Precarious Arrangements

As with their Slovak counterparts, Dutch agencies tend to be small or medium-sized. While live-in care remains relatively rare in the Netherlands, the online visibility of these agencies has increased in recent years. Several providers have recently joined a sectoral association that represents providers of (live-in) home care services. The agencies position themselves as a "solution" to perceived shortcomings of the Dutch long-term care system. Across interviews, migrant live-in care is consistently contrasted with what respondents describe as the fragmentation of regular home-care services. While Slovak agencies are sometimes founded by former live-in caregivers, Dutch providers sometimes cite personal experiences of arranging care for family members within the Dutch healthcare system as a motivation for establishing their organization. For example, one of the founders had a family member for whom they had previously set up a live-in care arrangement.

Dutch agencies that organise live-in care prefer not to be called agencies but rather "care providers" (*zorgaanbieders*). In the past, these organizations acted merely as brokers, bringing Dutch care recipients and migrant care workers or foreign agencies together. In recent years, they have transitioned into private

enterprises (Fudge & Hobden, 2018) that directly sell live-in care services to clients. This transition is closely related to changing Dutch policy instruments as we will explain hereafter.

The Dutch care-providing organizations present themselves as operating in, but also against, a dense web of Dutch regulations, protocols and institutional expectations. One care provider repeatedly stressed that "the Dutch healthcare system, or systems, are not geared towards this," referring to cross-border arrangements. From their perspective, rules that were designed with domestically rooted institutions in mind are poorly suited to organizations that operate transnationally. This becomes especially tangible in the requirements tied to the WTZA, which entered into force in 2022. To meet the WTZA notification requirement, every care provider must, among other things, provide a Chamber of Commerce number and demonstrate that they have a client record system, a quality management system with written protocols, and a client council. One interviewee underscores how difficult this is for agencies or individual care workers whose operational centre is not in the Netherlands, asking us to imagine "organizing a client council from your office in Lisbon or somewhere in Poland" (Peter, manager at a Dutch care provider organization).

Against this backdrop, providers have adapted by strategically reshaping their formal role in the system. Where in the earlier constellation the Dutch agency acted as an intermediary, and it was the international care provider (e.g., a Slovak agency) who had a contract with the client, since the tightened quality control regulations of 2022, Dutch agencies have become the formal providers of care. Meanwhile, in reality, many arrangements, such as recruitment through partner agencies abroad, remain unchanged. This move can be seen as a way of aligning with the regulatory expectations that structure the Dutch welfare market. A Dutch entity now sits at the interface with the state, formally complying with all regulatory requirements. This shift can also be understood as a form of corporatization (Farris & Marchetti, 2017). The organization takes on the shape and language of an institutional care provider, with quality systems, protocols and formal client councils, not only to meet legal standards, but also to gain faster access to public money and to be recognised as a legitimate actor in the field.

Formal compliance does not eliminate the grey zones that characterise migrant live-in care. While providers claim to pay according to the collective labour agreement and to respect a 40-hour work week (see also Da Roit & Van Bochove, 2017), the accounts of care workers being required to be constantly available put that into question. Here we need to acknowledge that agencies differ (Leiber et al., 2019). Some Dutch agencies may prioritise and have more success in maintaining minimum labour standards than others. However, because the employment or contractual relationship with care workers is outsourced to partner agencies abroad, who in turn—at least in our Slovak case study—engage self-employed care workers, the responsibility for and control over working conditions is shifted away from the Dutch providers. Consequently, the transition from intermediary to formal care provider is both a tactic to navigate Dutch bureaucracy and a mechanism that keeps much of the transnational and precarious character of live-in care hidden "behind the scenes," even as the care providing organizations present themselves as fully aligned with Dutch rules and institutions.

6. Enforcement Gaps and How Precarity Remains Invisible for Dutch Regulatory Authorities

In this section, we zoom in on how instruments of information and enforcement affect the dynamics of the Dutch live-in care market. As we already noted in Section 4, Dutch authorities record little information on

live-in care work and regulatory responsibility is dispersed and divided between different institutions responsible for eligibility, financing, care quality, and working conditions. This institutional distribution shapes what aspects of live-in care become visible to regulators, and which remain outside their scope, as is graphically depicted in Figure 1 and further explained below.

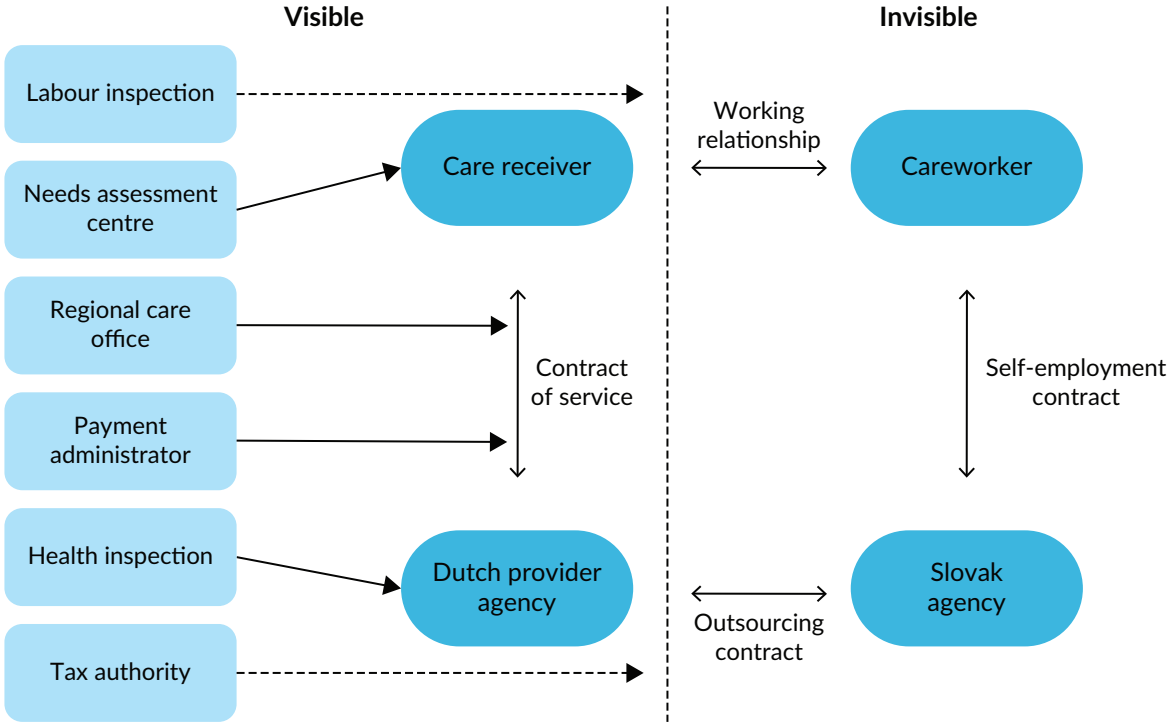


Figure 1. What is visible and invisible for Dutch regulatory authorities.

The needs assessment centre determines eligibility for publicly funded long-term care and the level of care required, but not the form in which this is provided. Once eligibility is established, regional care offices evaluate whether care recipients are eligible for personal budget funding. In the case of live-in care, these offices function as important gatekeepers because they approve the contracts through which care is organised. However, an interview with a representative from one care office suggests that this form of care is not systematically monitored. Service contracts (*zorgovereenkomst*) categorize services in ways that do not distinguish live-in care from other forms of home care, which limits the institutional visibility of the practice.

Yet another institution (the social insurance bank) acts as payment administrator and pays out personal budget funds to care providers, in this case the Dutch care-providing organizations. According to one of our interviewees, in the past, the payment administrator treated international providers as inherently risky. Dutch authorities "see something foreign and immediately: Hey! All the red flags" (Peter, manager at a Dutch care provider organization). Even after passing initial checks, foreign providers would remain subject to repeated scrutiny, as though their foreignness alone constituted grounds for continued suspicion. Only after the formal care provider became a Dutch organization—which still subcontracted services to the same international providers as before—payments were administered directly and without much critical scrutiny. This development of channelling personal budgets through Dutch care-providing organizations has important implications, as it has made intermediaries, such as Slovak employment agencies, and the care workers themselves *less* visible within the administrative structure, as is visualized in Figure 1.

Another important enforcement authority is the Dutch Health and Youth Care Inspectorate, which supervises whether formally registered care providers comply with professional standards and safety requirements. We retrieved a recent inspection report of a live-in care provider, which illustrates how this regulatory framework encounters the organizational model typical of the sector (the report is not cited here to preserve the anonymity of the organization, but it was retrieved from the Health and Youth Care Inspectorate, 2026). The inspection report shows that the Inspectorate is aware of the organizational model of the provider, noting that it works with a foreign subcontractor and self-employed foreign carers who live-in and work for six consecutive weeks in the Netherlands. Yet the Inspectorate does not engage with this revelatory information in any way. It does not signal that this constellation likely involves bogus self-employment according to Dutch law, nor does it address the working conditions of these care workers. Instead, the report focuses on qualifications obtained abroad that had not been formally recognised within the Dutch professional framework as well as missing criminal background checks. Rather than problematising the staffing model, the inspectorate addresses these issues through its standard quality-improvement approach. The Dutch provider is required to ensure that caregivers possess qualifications recognised in the Netherlands and obtain the necessary background checks. The report then expresses confidence in the provider's capacity to implement improvements. This example shows how fragmentation of control leads to a situation where, even when potentially problematic cross-border labour arrangements become partly visible, this information is not shared with the authority responsible for working conditions.

Meanwhile, the Dutch labour inspectorate, the authority that enforces labour standards, is hampered by limited knowledge of the live-in care market and the absence of an easily controllable workplace. In recent years, it has encountered several individual cases of severe transgression of labour standards in live-in care, much in line with practices described by care workers in our fieldwork (see, for example, Nederlandse Arbeidsinspectie, 2022, p. 25), yet the labour inspectorate only acts after a worker or an NGO has signalled exploitative practices (Van Wanroij, 2025a). That this is unlikely to resolve systematic problems can be inferred from our fieldwork, which showed that Slovak care workers do not know who is responsible for their working conditions, let alone possess the legal and language capabilities to involve Dutch authorities.

Finally, the invisibility of Slovak self-employed care workers is reinforced by the fact that their economic activities remain formally rooted in Slovakia. They are paid by Slovak agencies, pay taxes in Slovakia, and sign a European A1 form—this is frequently mentioned by our interviewees—which certifies that they fall under Slovak social security regulations. Consequently, their work never becomes visible to the Dutch tax or social security authorities. This is important, because it is exactly the Dutch tax authority that has recently tightened its enforcement of self-employment regulations to combat bogus self-employment (Rijksoverheid, 2024), i.e., situations where self-employed (care) workers do not retain control over how and when they work, or do not have multiple clients. Consequently, while Dutch care-providing organizations and self-employed care workers registered in the Netherlands risk prosecution when they engage in practices of bogus self-employment, this practice has so far gone unpunished when outsourced to foreign subcontractors.

Taken together, these arrangements reveal systematic limits to institutional oversight in the highly regulated Dutch care market. Responsibilities are fragmented across multiple organizations and the working conditions of live-in care workers often remain administratively invisible. Funding institutions oversee care budgets and contracts but have no institutional responsibility for labour relations. Meanwhile, practices of bogus

self-employment and labour exploitation remain mostly invisible to the organizations responsible for enforcement, such as the Labour Inspectorate and the Tax Authority.

7. Conclusion

It has been suggested that the highly regulated nature of the Dutch cash-for-care benefit limits regulatory grey zones (Böcker et al., 2021) and improves working conditions (Da Roit & Van Bochove, 2017) in comparison with other less-regulated cash-for-care schemes (Da Roit & Le Bihan, 2010; Van Hooren, 2012). Our findings indicate that this is not the case: Agencies actively produce semi-formal "in-between spaces" through legal and organizational workarounds. In a heavily regulated market, live-in care is organised through subcontracting chains that obscure highly flexible employment arrangements, most commonly self-employment. When regulations are tightened, information about employment relations is actually lost, and effective oversight becomes more difficult. Subcontracting chains and self-employment allow agencies in the Netherlands and Slovakia to avoid obligations related to working time, guaranteed rest, and paid leave (Aulenbacher et al., 2021).

Vulnerability is therefore not an unintended side effect but an integral element of the model, making the state complicit (Lutz & Palenga-Möllenbeck, 2010). While Dutch care-providing agencies present themselves as facilitators of formal care, both Dutch and Slovak agencies profit from operating within weakly enforced regulatory spaces through subcontracting and self-employment arrangements that shift risks and responsibilities onto care workers. This produces a persistent asymmetry of power between agencies and caregivers and reflects broader processes of marketization and commodification of care that reproduce structural inequalities and precarization within private households (Uhde, 2016, p. 395; Uhde & Ezzeddine, 2020, p. 27). As a result, care and labour standards are continuously negotiated in practice and depend on the specific situation (Böcker et al., 2021; Steiner et al., 2020). Limited language proficiency further weakens caregivers' bargaining power and reproduces gendered, ethnic, class-based, and power asymmetries within live-in care arrangements (Bahna, 2020; Fedyuk, 2020).

These vulnerabilities do not stem from an absence of regulation as such, but rather from regulatory gaps, workaround practices, and the transnational organization of care within private households. The case thus reveals a paradox of welfare governance: The design of funding, regulation, information, and enforcement systems simultaneously structures what becomes governable and what remains unseen, allowing formal compliance to coexist with persistent blind spots. More generous public subsidies or tightened regulations do not necessarily improve working conditions.

This Dutch–Slovak case study, premised on generous Dutch cash-for-care benefits, suggests that 24-hour live-in care can hardly be organised in a financially sustainable way while also adhering to minimum labour standards. According to European standards, also applicable in the Netherlands, all on-call time where care workers are not allowed to leave the house should be counted and paid as working time (Rijksoverheid, 2026b; Van Wanroij, 2025b). Consequently, 24-hour care paid at Dutch minimum wage would cost some EUR 10,000 per month for labour costs only (hence excluding intermediary costs, taxation, or social security benefits), which already amounts to nearly twice the level of the Dutch cash-for-care benefit.

Meanwhile, given that live-in care work is a reality that is not likely to disappear soon, our case study echoes some concrete points of attention for protecting working conditions in welfare markets, which have also been brought forward in other research. First, live-in care workers should be given more systematic time off, also during the night, and regulation needs to limit the possibility of using self-employment arrangements in live-in care (Österle & Bauer, 2016; Sagmeister, 2024; Schmidt et al., 2016). Second, authorities must gather information by requiring registration in the country where care is provided and creating administrative categories that specifically reflect live-in care work. Third, the authorities that control welfare markets must cooperate and make the enforcement of working conditions one of their priorities.

Acknowledgments

We sincerely thank all our interviewees for their participation in this study. We also thank Kristine Krause and Petra Ezzeddine for their enthusiasm, encouragement, and support throughout the research and writing process. We thank the editors of the thematic issue and three anonymous reviewers for their very valuable and highly constructive feedback.

Funding

The research conducted for this article was financed by a Volkswagen Foundation grant for the project "Researching the Transnational Organization of Senior Care, Labour and Mobility in Central and Eastern Europe" (CareOrg, 2023–2026; https://careorg.eu). The final writing stage of the article was enabled by the project "Breaking the Silence: Politics, Workers' Rights and the Future of Senior Care in Europe" (VI.Vidi.231R.053), which is financed by the Dutch Research Council (NWO).

Conflict of Interests

In a future Horizon Europe "Rights4CareWork" research project, one of the authors (Franca van Hooren) will collaborate with the NGO Fairwork, which fights labour exploitation of migrant workers in—among other sectors—live-in care work in the Netherlands.

Correction Statement

This article has been republished with minor corrections to fix spelling, grammar mistakes, and/or typos. These changes have no impact on the scientific content of the article as it was originally published.

Data Availability

This article is based on fieldwork and interview data that are not disclosed for reasons of anonymity and privacy. All other sources are listed as references.

LLMs Disclosure

UvA AI Chat was used for language editing of a few segments of the article.

References

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Aulenbacher, B., Lutz, H., & Schwiter, K. (2021). *Gute Sorge ohne gute Arbeit? Live-in-Care in Deutschland, Österreich und der Schweiz*. Beltz Juventa.

Bahna, M. (2020). The economic rationales behind crossborder care among care workers from Slovakia. In N. Katona & A. Melegh (Ed.), *Towards a scarcity of care* (pp. 92–114). Friedrich Ebert Stiftung.

Bahna, M., & Sekulová, M. (2018). *Crossborder care: Lessons from Central Europe*. Palgrave Macmillan.

Boccagni, P. (2017). At home in home care? Contents and boundaries of the 'domestic' among immigrant live-in workers in Italy. *Housing Studies*, *23*(5), 813–831. https://doi.org/10.1080/02673037.2017.1367366

Böcker, A., Bruquetas-Callejo, M., Horn, V., & Schweppe, C. (2021). "This is affordable!" The role of money matters in the use of live-in migrant care arrangements. In T. de Lange & Schrauwen, A. (Eds.), *Money matters in migration: Policy, participation, and citizenship* (pp. 149–168). Cambridge University Press.

Bruquetas-Callejo, M. (2019). Long-term care crisis in The Netherlands and migration of live-in care workers: Transnational trajectories, coping strategies and motivation mixes. *International Migration*, *58*(1), 105–118. https://doi.org/10.1111/imig.12628.

Bundesministerium für Arbeit. (n.d.). *Care and support*. https://www.sozialministerium.gv.at/en/Topics/Care/Care-and-Support.html

Bundesministerium für Gesundheit. (n.d.). *Pflegegeld*. https://www.bundesgesundheitsministerium.de/pflegegeld

Burri, S., Heeger-Hertter, S., & Rossetti, S. (2018). *On-call work in the Netherlands: Trends, impact and policy solutions*. https://www.ilo.org/publications/call-work-netherlands-trends-impact-and-policy-solutions

CBS Statline. (n.d.). *AZW StatLine*. https://azwstatline.cbs.nl/#/AZW/nl

Da Roit, B. (2018). Long-term care reforms in the Netherlands: Care work at stake. In K. Christensen & D. Pilling (Eds.), *The Routledge handbook of social care work around the world* (pp. 61–73). Routledge.

Da Roit, B., & Le Bihan, B. (2010). Similar and yet so different: Cash-for-care in six European countries' long-term care policies. *Milbank Quarterly*, *88*(3), 286–309. https://doi.org/10.1111/j.1468-0009.2010.00601.x

Da Roit, B., & Van Bochove, M. (2017). Migrant care work going Dutch? The emergence of a live-in migrant care market and the restructuring of the Dutch long-term care system. *Social Policy & Administration*, *51*(1), 76–94.

Daly, T., Charlesworth, S., Jacobsen, F. F., & Laxer, K. (2025). Counting care workers: When the 'muddle' is the message. In T. Daly & S. Braedley (Eds.), *Ageing equitably with care* (pp. 68–93). Policy Press. https://doi.org/10.51952/9781447375067.ch005

Ezzeddine, P., & Matiaško, M. (2026). Live-in care on trial: The failed promise of solidarity in European care governance. *Economy and Society*, *55*(2), 347–365. https://doi.org/10.1080/03085147.2026.2631338

Farris, S. R., & Marchetti, S. (2017). From the commodification to the corporatization of care: European perspectives and debates. *Social Politics International Studies in Gender State & Society*, *24*(2), 109–131. https://doi.org/10.1093/sp/jxx003

Fedyuk, O. (2020). Migrants' embodied geographies: Spaces and boundaries of care work. Case study of Ukrainian care workers in Italy. In N. Katona & A. Melegh (Ed.), *Towards a scarcity of care* (pp. 143–165). Friedrich Ebert Stiftung.

Fudge, J., & Hobden, C. (2018). *Conceptualizing the role of intermediaries in formalizing domestic work* (Working Paper No. 95). International Labour Office.

Gábriel, D. (2020). Negotiating working conditions—Hungarian care workers in the Austrian live-in care sector. In N. Katona & A. Melegh (Ed.), *Towards a scarcity of care* (pp. 115–142). Friedrich Ebert Stiftung.

Health and Youth Care Inspectorate. (2026). *Toezichtdocumenten. Inspectie Gezondheidszorg en Jeugd*. https://toezichtdocumenten.igj.nl

Hoppania, H.-K., Karsio, O., Näre, L., Vaittinen, T., & Zechner, M. (2024). Financialization of eldercare in a Nordic welfare state. *Journal of Social Policy*, *53*(1), 26–44. https://doi.org/10.1017/S0047279422000137

Ledoux, C., Shire, K. A., & Van Hooren, F. (2021). The dynamics of welfare markets: Private pensions and domestic/care services in Europe. Springer. https://doi.org/10.1007/978-3-030-56623-4

Leiber, S., Matuszczyk, K., & Rossow, V. (2019). Private labor market intermediaries in the Europeanized live-in care market between Germany and Poland: A typology. *Zeitschrift Für Sozialreform*, *65*(3), 365–392. https://doi.org/10.1515/zsr-2019-0014

Leiblfinger, M., Prieler, V., Rogoz, M., & Sekulová, M. (2021). Confronted with COVID-19: Migrant live-in care during the pandemic. *Global Social Policy*, *21*(3), 490–507. https://doi.org/10.1177/14680181211008340

Lobel, O. (2001). Class and care: The roles of private intermediaries in the in-home care industry in the United States and Israel. *Harvard Journal of Law and Gender*, *24*, 89–137.

Lutz, H., & Palenga-Möllenbeck, E. (2010). Care work migration in Germany: Semi-compliance and complicity. *Social Policy and Society*, *9*(3), 419–430. https://doi.org/10.1017/s1474746410000138

Marcus, G. E. (1995). Ethnography in/of the world system: The emergence of multi-sited ethnography. *Annual Review of Anthropology*, *24*, 95–117. http://www.jstor.org/stable/2155931

Ministerie van Volksgezondheid. (2025a, March 24). *Gebruik Wlz-zorg naar leveringsvorm*. https://www.monitorlangdurigezorg.nl/kerncijfers/gebruik/gebruik-wlz-zorg-naar-leveringsvorm

Ministerie van Volksgezondheid. (2025b, September 12). *Alles over de meldplicht*. https://www.toetredingzorgaanbieders.nl/melden

Nederlandse Arbeidsinspectie. (2022). *Monitor arbeidsuitbuiting en ernstige benadeling 2020–2021*.

Österle, A., & Bauer, G. (2016). The legalization of rotational 24-hour care work in Austria: Implications for migrant care workers. *Social Politics*, *23*(2), 192–213. https://doi.org/10.1093/sp/jxv001

Rijksoverheid. (2024). *Vanaf 1 januari 2025 volledige handhaving op schijnzelfstandigheid*. https://www.rijksoverheid.nl/actueel/nieuws/2024/09/06/vanaf-1-januari-2025-volledige-handhaving-op-schijnzelfstandigheid

Rijksoverheid. (2026a). *Het juiste contract: Zzp ja of nee?* https://www.rijksoverheid.nl/themas/werk/zelfstandigen-zonder-personeel-zzp/voorkomen-van-schijnzelfstandigheid

Rijksoverheid. (2026b). *Wat zijn de regels bij consignatie (oproepdienst)?* https://www.rijksoverheid.nl/vraag-en-antwoord/werktijden/welke-regels-gelden-bij-oproepdiensten-consignatie

Sagmeister, M. (2024). The legal regulation of domestic care work in Austria. *Revue des politiques sociales et familiales*, *150*(1), 117–133. https://doi.org/10.3917/rpsf.150.0117

Sagmeister, M. (2025). Social security coordination and circular migration within the EU: A case study on the pension and unemployment entitlements of Eastern European mobile care workers in Austria. *European Journal of Social Security*, *27*(3), 233–250. https://doi.org/10.1177/13882627251369480

Schmidt, A. E., Winkelmann, J., Rodrigues, R., & Leichsenring, K. (2016). Lessons for regulating informal markets and implications for quality assurance: The case of migrant care workers in Austria. ageing and society, *36*(4), 741–763. https://doi.org/10.1017/S0144686X1500001X

Seiffarth, M. (2023). Collective bargaining in domestic work and its contribution to regulation and formalization in Italy. *International Labour Review*, *162*(3), 505–528. https://doi.org/10.1111/ilr.12382

Shutes, I., & Chiatti, C. (2012). Migrant labour and the marketisation of care for older people: The employment of migrant care workers by families and service providers. *Journal of European Social Policy*, *22*(4), 392–405.

Steiner, J., Prieler, V., Leiblfinger, M., & Benazha, A. (2020). Truly legal!? Legal framing and legality narratives in live-in care in Austria, Germany and Switzerland. In N. Katona & A. Melegh (Eds.), *Towards a scarcity of care?* (pp. 69–91). Friedrich-Ebert-Stiftung.

Trukeschitz, B., Österle, A., & Schneider, U. (2022). Austria's long-term care system: Challenges and policy responses. *Journal of Long-Term Care*, *2022*, 88–101. https://doi.org/10.31389/jltc.112

Uhde, Z. (2016). From women's struggles to distorted emancipation: The interplay of care practices and global capitalism. *International Feminist Journal of Politics*, *18*(3), 390–408.

Uhde, Z., & Ezzeddine, P. (2020). The political economy of translocal social reproduction: Cross-border care mobility in the Czech Republic. In N. Katona & A. Melegh (Ed.), *Towards a scarcity of care* (pp. 26–47). Friedrich Ebert Stiftung.

Ungerson, C., & Yeandle, S. (2007). *Cash for care systems in developed welfare states*. Palgrave Macmillan.

Van Hooren, F. J. (2012). Varieties of migrant care work: Comparing patterns of migrant labour in social care. *Journal of European Social Policy*, *22*(2), 133–147. https://doi.org/10.1177/0958928711433654

Van Hooren, F. J. (2018). Intersecting social divisions and the politics of differentiation: Understanding exclusionary domestic work policy in the Netherlands. *Social Politics*, *25*(1), 92–117. https://doi.org/10.1093/sp/jxx019

Van Wanroij, A. (2024, October 11). *24 uur beschikbaar moeten zijn, maar minder dan minimumloon krijgen: Buitenlandse zorgverleners worden uitgebuit door Nederlandse zorgbureaus*. EenVandaag. https://eenvandaag.avrotros.nl/artikelen/24-uur-beschikbaar-moeten-zijn-maar-minder-dan-minimumloon-krijgen-buitenlandse-zorgverleners-worden-uitgebuit-door-nederlandse-zorgbureaus-152529

Van Wanroij, A. (2025a, June 17). *Arbeidsinspectie pakt 3 verdachten op voor uitbuiting van buitenlandse vrouwen in 24-uurszorg*. EenVandaag. https://eenvandaag.avrotros.nl/artikelen/arbeidsinspectie-pakt-3-verdachten-op-voor-uitbuiting-van-buitenlandse-vrouwen-in-24-uurszorg-160540

Van Wanroij, A. (2025b, December 11). *Hoe nieuw keurmerk misstanden in 24-uurszorg moet voorkomen: "Kwetsbaarheden zijn duidelijk."* EenVandaag. https://eenvandaag.avrotros.nl/artikelen/hoe-nieuw-keurmerk-misstanden-in-24-uurszorg-moet-voorkomen-kwetsbaarheden-zijn-duidelijk-162187

About the Authors



Siënna Hernandez is a PhD candidate in anthropology at Leipzig University. Her research focuses on care work and other forms of labour within healthcare systems. She is particularly interested in how these forms of work are organised, experienced, and valued in everyday practice.



Kristína Bartošová is a master's student in sociocultural anthropology at Charles University in Prague. Her research focuses on Slovak live-in care workers in the Netherlands and on how care is organised, experienced, and shaped by transnational care infrastructures.



Franca van Hooren is an associate professor in political science at the University of Amsterdam. She researches care policies and the political representation of care workers and leads the research project "Breaking the Silence: Politics, Workers' Rights and the Future of Senior Care in Europe."

Social Inclusion
2026 • Volume 14 • Article 12737
https://doi.org/10.17645/si.12737

cogitatio

BOOK REVIEW

Open Access Journal

Home Care for Sale: Marketisation and Social Change

Attila Melegh [1,2]

[1] Demographic Research Institute, Hungary
[2] Corvinus University of Budapest, Hungary

Correspondence: Attila Melegh (melegh@demografia.hu)

Submitted: 5 May 2026 **Accepted:** 7 May 2026 **Published:** 8 June 2026

Issue: This book review is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

The evolving crises, contradictions of care, marketisation, and demographic developments are clear, substantial, and inevitable, and are driving social change. In this context, the book *Home Care for Sale: The Transnational Brokering of Senior Care in Europe*, which highlights some of these contradictions, is essential reading. More importantly, it provides valuable insights. Rather than offering simplistic critiques, we need to consider contradictions because we must understand not only how societies (and vulnerable groups) struggle due to certain institutional arrangements, but also how to find innovative solutions to social problems and care gaps due to social tensions. Few people dare to consider how societies not only collapse, but also innovate under neoliberal stress.

Keywords

ageing; care; labour; marketisation; social change

We are living in turbulent times. We are witnessing significant social change, with social institutions under severe strain in the neoliberal era. The entire geopolitical order is under dramatic stress and the prospect of much larger-scale warfare is looming. The neoliberal era and its market-driven changes promise a bleak and insecure future. During this period, it is crucial to consider how we can organize and guarantee basic social services, such as care and support for our families, neighbours, and fellow residents. Such concerns are especially pressing in the context of demographic ageing and the increasing demand for both the quantity and diversity of care services. Nevertheless, relative to needs, governments reduced redistributive capacities over recent decades: Tax revenues as a percentage of GDP declined after the global crisis of 2008 and have stagnated ever since, except during the Covid-19 pandemic (Melegh, 2023). Under these conditions, only

© 2026 by the author(s), licensed under a Creative Commons Attribution 4.0 International License (CC BY).

substantial economic growth could cover the cost of social support and the rapidly rising cost of healthcare. The evolving crisis is therefore clear, significant, and unavoidable, pushing social change forward.

In this context, *Home Care for Sale: The Transnational Brokering of Senior Care in Europe* (Aulenbacher et al., 2024) provides an important contribution to debates on care, labour, and marketisation. Rather than offering a simplistic critique of neoliberalism, the volume examines the contradictions embedded in contemporary care arrangements. It demonstrates not only how vulnerable groups experience increasing precarity under existing institutional structures, but also how new forms of adaptation and innovation emerge in response to care deficits and social inequalities. In this respect, the book highlights both the destructive and transformative dimensions of neoliberal restructuring.

Before discussing the book's key analytical aspects, it is important to note that the volume is an edited collection consisting of chapters by numerous authors, each providing a critical analysis of related issues in different national contexts. Each chapter functions as an independent contribution and provides an insightful theoretical overview. Although this occasionally results in repetition, the editors successfully establish a coherent analytical framework that integrates a wide range of empirical cases and theoretical perspectives. This framework represents one of the volume's major strengths and effectively turns the book into a comprehensive overview of the marketisation of care and its mechanisms.

The first major topic in the book is marketisation itself. The book clearly argues that the commodification of care reflects the ways in which capitalist economies increasingly integrate care and care work into market relations despite their socially reproductive character. This holistic approach is important because marketisation is a complex process that cannot be confined to a single definition. In fact, recent scholarship has similarly emphasized the conceptual complexity of commodification (Bertrand & Panitch, 2023). Furthermore, in our view, marketisation should be understood as a complex historical process characterized by recurring waves and transformations (Burawoy, 2020).

Within the volume marketisation refers to several interconnected and parallel processes. Firstly, since the early 1990s, key global economic forces and organisations have promoted the expansion of transnational labour markets (Chawla et al., 2007; van der Linden & Roth, 2014; World Bank, 1995). The rise of the global care labour market represents a particularly significant aspect of this transformation (Hoerder et al., 2015). This new global labour market and care labour market needs new and organized types of matchings operating both online and offline. As demonstrated in the chapter by Gábriel and Katona, brokerage structures have become increasingly important within care sectors. This development is increasingly based on migrant labour and market-mediated relations. At the same time, care, labour, and migration are becoming ever more fictitious, allowing the system to commodify and exploit resources that are not originally produced for market exchange (Polanyi, 2001).

The volume further suggests that care labour has become what might be described as a "super-fictitious" commodity. Care labour is commodified labour, but it is also tied to socially reproductive activities that historically existed outside market relations. Furthermore, it is migrant labour, which is even more socially decontextualised—being often managed via market-oriented brokers—with massive consequences for transnational family relations (Aulenbacher & Handapangoda, 2025). This labour is frequently performed within home-like environments that blur the boundaries between domestic life and the workplace, as

discussed in the chapter by Lutz and Benazha. To illustrate this radically disembedded scenario, one Hungarian care worker explained in an interview that she migrated to Austria after her husband became permanently ill and unable to work (Melegh et al., 2018). Such cases demonstrate how neoliberal arrangements compel families to adapt to transnational labour demands that may override their own social and emotional needs. All of this happens in pseudo-home-like workplaces that are generally not acknowledged as workplaces, but merely as locations for the provision of services. Thus, care labour becomes super fictitious, a scenario amply illustrated in the book.

The book also provides an analytical guide to the radicalisation of inequalities within transnational care systems. Several chapters examine the role of brokers and agencies in structuring labour relations. Mercille's chapter analyses brokerage businesses in Ireland, while Aulenbacher and Prieler examine the branding strategies of agencies operating within Austria's self-employed care-worker regime. Gábriel and Katona provide a typology of brokerage structures in Hungary. Palenga-Möllenbeck further demonstrates that brokerage relations between Germany and Poland are themselves hierarchically organized, producing unequal divisions of labour and revenue between German and Polish agencies. These arrangements reinforce broader East–West inequalities within European care systems and generate additional forms of rent extraction (Katona & Melegh, 2020).

The East–West divide constitutes a recurring theme manifesting in various aspects of the semi-peripheral position of Eastern Europe. Eastern Europe has become a major provider of migrant care labour, producing significant forms of care drain. At the same time, Eastern European care workers are often racialised through representations that position them as an inferior form of "Europeanwhiteness" (Böröcz & Sarkar, 2017; Melegh, 2006). As discussed in Uhde's chapter, this racialisation also shapes negative attitudes towards refugees and migrants from other parts of the world. Furthermore, massive inequalities emerged during the Covid-19 crisis when East–West hierarchies became crucial selection mechanisms during border closures. Eastern European workers often assumed high-risk positions within care and food production sectors. As Ezzedine demonstrates, many care workers accepted significant personal risks in order to maintain care provision during the pandemic labour.

To make matters worse, these structural inequalities occur in emotionally charged settings, where conflicts are difficult to resolve due to power relations embedded in marketisation. There is a lack of distinction between work and leisure spaces, and related spatial divisions of labour. Familial environments become work environments where workers are poorly protected. Giordano's chapter shows how brokerage systems in Belgium capitalize on social and economic inequalities, while similar processes of rent extraction are documented in Spain by Martínez-Buján and Moré. Thus, receiving homes become workplaces where conflicts are twisted. In such situations, market-oriented brokers often intervene with special interests, as Amorosi demonstrates in the Italian case.

It is no surprise that workers react to such conditions by becoming "professionals" in order to secure some limited forms of legal and social protection. This professionalisation can be regarded as a countermovement to the marketisation of care work, without challenging market relations. As discussed by Lutz and Benazha, professionalisation may therefore function simultaneously as a response to and reinforcement of marketisation. Workers do not necessarily embrace commodified labour relations; rather, they attempt to navigate among intersecting forms of vulnerability and exploitation (Fraser, 2022; Goikoetxea, 2024). These

dynamics illustrate the contradictory nature of marketisation and the diverse forms it may assume. This is why the book should not be read merely as a critique, but as an analysis of the key tensions shaping the future of care, labour, and broader systems of social reproduction.

This tension comes up directly in the final section of the book, where the concluding analytical points concerning the struggle over rights, exploitation, ethics, and fairness as fundamental aspects of contradictory marketisation are discussed. Contributions by Edmunds, Schwiter, and Kaddour, and Fouskas and Schilliger document a range of initiatives and practices—already implemented—that seek to address existing inequalities. There is evidence here of a great deal of innovation, including the use of various forms of social capital, such as ethnic bonds, or additional resources utilized by care workers in the form of trust and solidarity networks, dimensions that remain insufficiently addressed in labour movement studies. However, as Fraser and Van der Linden have pointed out, it is not only "normal" and "normalised" wage labour that should be incorporated into our critical work, but also forced labour and domestic labour, in order to do justice to workers, at least from an epistemological perspective (Fraser, 2022; van der Linden & Roth, 2014). From this perspective, care work must be understood as central to the functioning of capitalist societies rather than as a marginal or secondary form of labour.

At the same time, we should also recognise that capitalist 'servitude' is inherited and developed from status-based systems of family arrangements in historical times. Historical cycles of marketisation have been key driving forces in this historical process (Hoerder et al., 2015; Kertzer & Laslett, 1995). In this respect, *Home Care for Sale: The Transnational Brokering of Senior Care in Europe* offers important insight into the changing organisation of care within contemporary capitalism and provides a valuable analytical framework for understanding current transformations in social reproduction. It is exactly the intellectual contribution that we need in our turbulent times.

Conflict of Interests

The author declares no conflict of interests.

LLMs Disclosure

LLMs have been used in the linguistic editing of this manuscript, in a supervised manner.

References

Aulenbacher, B., & Handapangoda, W. (2025). A global migration industry in local contexts: Home care and domestic work brokerage in Austria and Sri Lanka. *International Sociology*, *40*(6), 887–906. https://doi.org/10.1177/02685809251318642

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (Eds.). (2024). *Home care for sale: The transnational brokering of senior care in Europe*. Sage.

Bertrand, É., & Panitch, V. (Eds.). (2023). *The Routledge handbook of commodification*. Routledge.

Böröcz, J., & Sarkar, M. (2017). The unbearable whiteness of the Polish plumber and the Hungarian peacock dance around "race." *Slavic Review*, *76*(2), 307–314. https://doi.org/10.1017/slr.2017.79

Burawoy, M. (2020). Fictitious commodities and the three waves of marketisation. In B. Aulenbacher, M. Marterbauer, A. Novy, K. Polanyi Levitt, & A. Thurnher (Eds.), *Karl Polanyi: The life and works of an epochal thinker* (pp. 33–40). Falter Verlag.

Chawla, M., Banerji, A., & Betcherman, G. (2007). *From red to gray: The third transition of aging populations in*

Eastern Europe and the former Soviet Union (Report No. 40532). World Bank Group. http://documents1.worldbank.org/curated/en/770511468032337003/pdf/405320Red0to0g101OFFICIAL0USE0ONLY1.pdf

Fraser, N. (2022). *Cannibal capitalism: How our system is devouring democracy, care, and the planet—and what we can do about it*. Verso.

Goikoetxea, J. (2024). Rethinking gender, race, and class from the concept of labour: Interview with Nancy Fraser. *Capital & Class*, *48*(2), 303–317. https://doi.org/10.1177/03098168241234119

Hoerder, D., van Nederveen Meerkerk, E., & Neunsinger, S. (Eds.). (2015). *Towards a global history of domestic and caregiving workers*. Brill.

Katona, N., & Melegh, A. (Eds.). (2020). *Towards a scarcity of care? Tensions and contradictions in transnational elderly care systems in Central and Eastern Europe*. Friedrich Ebert Stiftung.

Kertzer, D. I., & Laslett, P. (Eds.). (1995). *Aging in the past: Demography, society, and old age*. University of California Press.

Melegh, A. (2006). *On the East–West slope: Globalization, nationalism, racism and discourses on Central and Eastern Europe*. Central European University Press.

Melegh, A. (2023). *The migration turn and Eastern Europe: A global historical sociological analysis*. Palgrave Macmillan.

Melegh, A., Gábriel, D., Gresits, G., & Hámos, D. (2018). Abandoned Hungarian workers and the political economy of care work in Austria. *Szociológiai Szemle*, *28*(4), 61–87.

Polanyi, K. (2001). *The great transformation: The political and economic origins of our time* (2nd ed.). Beacon Press.

van der Linden, M., & Roth, K. H. (Eds.). (2014). *Beyond Marx: Theorising the global labour relations of the twenty-first century*. Brill.

World Bank. (1995). *World development report 1995: Workers in an integrating world—Executive summary* (Report No. 14867). World Bank. https://documents.worldbank.org/en/publication/documents-reports/documentdetail/632421468184149473/world-development-report-1995-workers-in-an-integrating-world-executive-summary

About the Author



Attila Melegh is a sociologist, economist, and historian. He studied economics and sociology at Karl Marx University of Economics and social history at Oxford University. He has a PhD in history from Debrecen University and received DSc from the Hungarian Academy. He is a habilitated full professor at Corvinus University, Budapest, and a scientific adviser at the Demographic Research Institute. Current editor of the *Eszmélet and Demográfia* (English edition) journal, he was the founding director of Karl Polányi Research Centre at Corvinus University between 2014–2022. He has been a Vienna Karl Polanyi Visiting Professor at Vienna University of Economics, University of Vienna, and Central European University. He is the president of the Demographic Committee of the Hungarian Academy of Sciences and a member of the European Academy. He is the 2025 winner of the Hungarian Academy prize. Author of *On the East/West Slope, Globalization, Nationalism, Racism and Discourses on Central and Eastern Europe*, his most recent work *The Migration Turn and Eastern Europe: A Global Historical Sociological Analysis* (2023, Palgrave-Macmillan)



SOCIAL INCLUSION
ISSN: 2183-2803

Social Inclusion is a peer-reviewed open access journal which provides academics and policymakers with a forum to discuss and promote a more socially inclusive society.

The journal encourages researchers to publish their results on topics concerning social and cultural cohesiveness, marginalized social groups, social stratification, minority-majority interaction, cultural diversity, national identity, and core-periphery relations, while making significant contributions to the understanding and enhancement of social inclusion worldwide.

cogitatio

www.cogitatiopress.com/socialinclusion