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A Care Convergence? Quantifying Wage Disparities for Migrant Care Workers Across Three Welfare Regimes

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A Care Convergence? Quantifying Wage Disparities for Migrant Care Workers Across Three Welfare Regimes

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Abstract

Social policy literature is divided on the ongoing relevance of welfare regime typologies given considerable heterogeneity within as well as between categories. Using 2010 Luxembourg Income Study data, this study disaggregates high and low status paid care work, quantifying any associate wage bonus or wage penalty, across three welfare regimes – liberal, conservative, and social democratic. In the majority of case study countries, immigrants are less likely to work in high status care than non-immigrants with equivalent human capital, suggesting access barriers to professional jobs in health, education and social work. The reverse pattern is evidenced in the case of low status service and sales work in care, demonstrating convergence across welfare regimes. However, there is also significant wage variation within care work. Pooled country models demonstrate a consistent wage bonus for high status care work, while regime type has a moderating effect in the case of low status care work, independent of immigrant status. A care wage penalty is found for both immigrants and non-immigrants working in low status care in liberal and conservative states, but no such penalty is found in the case of social democratic regimes.

Introduction

Within social policy literature there is a divide as to the ongoing relevance of welfare regime typologies. On the one hand, certain scholars suggest that welfare regime classifications are outdated and Eurocentric, and/or that differences within categories are more important than differences between them (e.g. Brennan, Cass, Himmelweit, & Szebehely, 2012; Jensen & Lolle, 2013). Williams (2012), for example, identifies considerable convergence in the provisioning of health, education, and social work ("care work") across wealthy European nations, both in the commodification of care services and in the employment of migrant women. Yet, on the other hand, many cross-national analyses of paid care employment continue to rely on grouping countries into "clusters" based on the quality of social rights, the extent of social stratification and the relation of state, market and family (e.g. Mahon, Anttonen, Bergqvist, Brennan, & Hobson, 2012; Michel & Peng, 2012). Budig and Misra (2010), as a seminal example, find significant wage variation across numerous welfare regimes, suggesting limitations to any purported care convergence.

The current study is the first to quantitatively measure care work across three welfare regimes – liberal, conservative/continental and social democratic - with a particular focus on the employment and earnings of immigrant workers. I examine the extent to which there has been a "care convergence" under conditions of globalization across welfare regimes, leading to a reliance on migrant women for low wage, low status work in care. In addition, I seek to quantify any "care bonus" or "care penalty" associated with high and low status care work across regime types. Using pooled country cumulative earnings models, I explore the impact of pertinent national-level conditions – welfare regime, immigrant composition, and income inequality – on

individual-level factors affecting wages – e.g. immigrant status, gender, family structure and human capital - as well as quantifying the moderating effect of work in care.

Using the micro data files of the Luxembourg Income Study (LIS) I examine who is employed in what type of care work and examine the earnings bonus/penalty for high and low-status (immigrant) care workers in twelve countries, in order to address the following key questions:

1. Does the care economy display evidence of convergence or divergence across three welfare regimes?
2. Are (female) immigrant workers more likely to work in low wage, low status care work than equivalent non-immigrant workers, regardless of welfare regime type, and do they incur a wage penalty?
3. What the impact, if any, do pertinent country-level conditions – and specifically welfare regime – have on care work wages cross-nationally?

Ultimately, I find that across the majority of case study countries immigrants are less likely to work in high status care than non-immigrants with equivalent human capital, while the reverse pattern is evidenced for low status care. This suggests access barriers to professional jobs in health, education, and social work, as well as a high degree of convergence across care economies. However, in terms of wage variation within care work, pooled country models demonstrate that regime type has a moderating effect. While a consistent 10-13% wage bonus is found for high status care work across regime type, a wage penalty is found for both immigrants and non-immigrants working in low status care in liberal and continental welfare regimes, while within social democratic regimes no such penalty exists. Thus, altogether, this paper contributes to existing welfare regime literature by adding nuance to prior suggestions of a care economy convergence and empirically demonstrating the influence of both individual and country-level factors on wages in high and low status care work.

Welfare Regime Theory and a Globalized Paid Care Market

Since the introduction of Esping-Andersen's formative typology of welfare regimes in *The Three Worlds of Welfare Capitalism* (1990), extensive research has espoused both the benefits and the limitations of fitting real welfare states into three or more ideal-type categories. Scholars supporting Esping-Anderson's "regime approach" posit that it is a useful mechanism to conceptualize and measure similarities and differences in social care provisioning at the cross-national level (e.g. Ebbinghaus, 2012; Saint-Arnaud & Bernard, 2003). However, those critiquing his methodology suggest that similarities within welfare regimes may be as significant as those across them, and/or that such classifications are outdated, homogenizing, and Eurocentric (e.g. Brennan et al., 2012; Jensen & Lolle, 2013).

Notwithstanding any limitations, Esping-Anderson's original classification scheme remains widely used in comparative social policy and prior studies using LIS data find consistent differences across regime types (e.g. Bradley, Huber, Moller, Nielsen, & Stephens, 2003; Huber, Stephens, Bradley, Moller, & Nielsen, 2009). Specifically, three "ideal-typical" regime types – liberal, conservative/continental, and social democratic – are frequently used to examine the varying roles of state, market, and family in the provisioning of social care (Budig & Misra, 2010; Williams, 2012). These regime types are distinguished based on the quality of social rights

guaranteed to residents, the welfare mix applied, and the degree of decommodification and stratification within the country (Aspalter, 2011; Fenger, 2007).

A brief discussion of each regime types is instructive. *Liberal* regimes, in particular, are thought to demonstrate a preference for market solutions to welfare problems, leading to relatively low levels of social spending, limited regulation of the labour market, and high levels of overall inequality (Banting & Myles, 2013) (Author, 2017). Such states assign "key roles to labour markets and families, with the state's role largely limited to providing assistance targeted at those least well-off" (Mahon et al., 2012, p. 421). Since the mid-twentieth century, liberal welfare regimes have experienced a consistent trend of converting the objectives of health and education from the delivery of a public good, to the sale of a market commodity tailored to specific (economically advantaged) groups.

By contrast, *conservative/corporatist* and *social democratic* regimes are thought to rely to a higher degree on state involvement in welfare provisioning (Sabbagh & Vanhuysse, 2010). Conservative regimes rely on familialism, allocating relatively generous welfare benefits largely on the basis of previous earnings. Thus, the interests of highly skilled and well-paid (predominantly male) jobholders are often privileged at the expense of young, unskilled, and female workers (who likely comprise a large proportion of low skill migrant care workers), imposing high family care burdens on women (Saint-Arnaud & Bernard, 2003). In addition, the formidable costs of child care in many conservative regimes makes it expensive for women to combine paid work with family life, leading to lower overall levels of female labour market participation and more informal provision of care (Sabbagh & Vanhuysse, 2010; Shire, 2015).

Social-democratic regimes, for their part, have the lowest levels of stratification, with generous benefits provided on a largely universal basis. Such regimes are characterized by comprehensive full-employment policies, and a strong network of public social services, provided for eligible citizens or residents "from the cradle to grave" (Beresford, 2016). While the state is even more broadly involved in welfare provisioning in social democratic than in conservative regimes, the former also actively promote the economic independence of women, typically by providing extensive and low-cost day care facilities and by stimulating female employment through public sector absorption and active labor market programs (Aspalter, 2011; Sabbagh & Vanhuysse, 2010).

Thus, altogether, Esping-Anderson's welfare regime typology suggests considerable variation across regime type in terms of social policies and care provisioning, with social democratic and conservative/continental regimes typically demonstrating lower levels of stratification and decommodification, or individual reliance on the market, than liberal regimes. The following section documents the specific devaluation associated with care work, as well as the increasing reliance on migrant women within care economies, found across welfare regime type.

Migration and the Devaluation of (Low Status) Paid Care Workers

Care work, typically defined as employment that involves face-to-face interactions with children, the elderly, or people with complex healthcare needs (England, Budig, & Folbre, 2002; Folbre, 2012), is frequently found to be undervalued and underpaid. Scholars seeking to explain this phenomenon provide three main explanations: First, the characteristics of care workers themselves (as a disproportionately female, racialized, and immigrant workforce) often lead to labour market disadvantages (Duffy, Albelda, & Hammonds, 2013; Folbre, 2012). Second, in the

case of low status care work, individuals are often negatively selected into these occupations based on low levels of education and other human capital, resulting in lower wages (England et al., 2002) (Author, 2018). Finally, the nature of lower status forms of care work itself devalues earnings, as such work is often disproportionately precarious and part time, and/or located in the unsubsidized private sector (Barron & West, 2013).

In tandem with this devaluation, lower status paid care employment is increasingly conceptualized within a transnational labour market (or "global care chain"), where disadvantaged or poor immigrant women provide care for pay in wealthier countries, typically in lower paying service jobs (Hochschild, 2012). In this context, migrant workers provide a market-based solution to national labour market shortages, often arriving with temporary work permits designed to discourage their broader integration or settlement and, in some cases, encountering widespread workplace discrimination and abuse, often while negotiating their own intergenerational family separations (Anderson & Shutes, 2014; Parreñas, 2013).

Thus, across numerous welfare regimes, female migrant labour has become a defining feature of the care economy (Kilkey, Lutz, & Palenga-Möllenbeck, 2010; Williams & Gavanas, 2008). Van Hooren (2012), for example, finds that migrant employees work longer hours and do more night shifts than their native-born peers in elder care in liberal welfare regimes, and that this polarization is especially acute for those employed in the private sector. In conservative welfare regimes, Shire (2015) finds that new policies in support of families have led to a growing reliance on migrant women in the realm of private domestic household work. And as a third example, in a comparison of Spain and Sweden, Hellgren (2015) notes that despite the different characteristics of their welfare regimes and markets, there are nonetheless similar results for migrant care workers, who have become an important and growing component of a "migrant precariat" within European societies.

Building on this existing scholarship, the current study provides a cross-national quantitative comparison of the outcomes of migrant care workers across welfare regime types. By incorporating national-level factors and measuring the moderating effect of work in high and low status care, a more nuanced analysis of any care convergence emerges.

Research Design

To examine care work across three welfare regimes – liberal, conservative/continental, and social democratic - this study uses 2010 data from Wave XIII of the Luxembourg Income Study (LIS). The LIS gathers cross-sectional data from national household-based surveys and harmonizes the data to ensure comparability. For the current analysis, the sample is limited to employed individuals aged 18-64 who are not enrolled as full-time students, resulting in a pooled sample size of 44,414 respondents, with per-country samples ranging from 1,388 individuals in France to 5,597 individuals in the United States (U.S.).

Building on Esping-Anderson's (1990) welfare regime classification, twelve countries are included in the study. Australia, Canada, Ireland, Switzerland, and the U.S. are designated "liberal" regimes, while Austria, France, Germany, Spain, and Italy are identified as "conservative/continental" regimes.[1] Denmark and the Netherlands represent the "social democratic" regimes. These case studies encompass all countries classified within the three welfare regimes that are included in the LIS data which have both a variable designating whether an individual is an immigrant or not, and which have detailed information on the occupation and industry of the respondent. While there is ongoing debate as to the correct welfare regime classification for some of the countries included,[2] they are classified in the most typical manner,

with the goal of measuring the care economy within each country and testing whether there are significant wage variations across regime types. Following Budig and Misra (2010), who suggest that macro-level factors may mitigate care work wage penalties, the analysis also includes controls for immigrant composition and national-level inequality, as well as regime type.

Classifying Work in Care

Following the dominant trend within quantitative cross-national care work comparisons (e.g. Budig & Misra, 2010; Duffy et al., 2013) (Author 2017, 2018), I identify individuals working for pay in the direct care industries of *education*, *health* and *social work*, relying on the LIS standardized industry variable. Given the considerable heterogeneity within these caring industries, in terms of both wages and occupational prestige, I draw on Weedon (2002), and use the International Standard Classification of Occupations (ISCO-08) to further differentiate between *professionals* and *services and sales workers* within the selected caring industries. This is done as a proxy for care work jobs with higher and lower status and greater or lesser social closure. Weedon (2002) identifies whether specific caring occupations control access to the profession and collectively negotiate employment conditions and benefits. A high degree of social closure ("high status" care) is exemplified in the case of professional occupations such as doctors and nurses, as well as many teachers. Care work jobs with low social closure ("low status" care) include occupations with high turnover and low entry barriers, including many service and sales jobs in health and education, such as teachers' aides and personal support workers (Barron & West, 2013) (Author, 2017). An individual must be identified as in both a caring occupation and a caring industry to be coded as having a care work job. Appendix 1 provides expanded details on the care work classification scheme developed and applied.

Variables of Interest

The dependent variables examine *who* engages in what type of care work and capture wage variations in high and low-status care, focusing on the employment and earnings of (female) immigrant workers. The main independent variables compare high-status and low-status care workers to individuals working in non-caring occupations, as well as comparing immigrants (defined here as people who were born outside of the country) to individuals born in the country.[3] Unfortunately, the LIS does not include consistent measures of respondents' race/ethnicity across datasets.

In order to specify any particular care bonus and/or penalty, as well as capture any specific effect of being an immigrant worker, as many conceptually relevant control variables as are available across the datasets are included in the final models. To account for the highly feminized nature of care work, a control for gender is included. Variables for family structure and demographic characteristics include a control for age, one for being married or cohabitating, and one for living with one's child aged 0-5 years. In addition, the potentially mediating effect of human capital is captured using educational attainment, relying on a categorical variable harmonized across countries. This variable has three categories: low (lower secondary education and less), medium (upper secondary education through to vocational post-secondary education), and high (university/college education and above). While job characteristics such as part time work status and employment in the public/non-profit sector also undoubtedly influence wages in care work (Author 2017, 2018), such variables are not consistently available across the case study countries and thus are not included in the final models.

Descriptive Overview of the National Care Economies

Initially, a descriptive overview of the care economy, by country, allows for an examination of broad trends within high and low status care work and across welfare regime type. Table 1 profiles the high and low status care workforce in each country, providing the percentage of the overall workforce employed in such jobs, and the immigrant and female composition within each type of care. Mean levels in each welfare regime type are also provided, in order to assess trends of care convergence or divergence.

Initially, it is notable that the care economy, on average, comprises a higher proportion of both high and low status care workers in the social democratic regimes. While this disparity may be due to the smaller number of countries included in the analysis, it also aligns with existing literature suggesting that social democratic regimes have higher levels of government workers and female labour force participation, along with more generous social services (Beresford, 2016). In all twelve countries, high status care work represents a higher proportion of the paid workforce than low status care work, bolstering prior suggestions that much non-professional caring labour in done through informal markets or by unpaid family (Folbre, 2012).

Nonetheless, variation is also observed both across and within welfare regimes. In terms of the proportion of immigrants working within the high and low status workforce, the liberal welfare regimes have higher proportions than the continental and social democratic regimes, on average. This, in part, is reflective of higher overall levels of immigration in these countries, quite separate from work in care.[4] In addition, in all countries besides Australia, Ireland, France and Italy, there is a higher proportion of immigrants working in low status care work than in high status care work. Immigrants comprise the highest proportion of high status care workers in Australia (at 29.7%) and the lowest proportion in Italy (at 3.0%). In the case of low status care workers, Switzerland has the highest proportion of immigrants (at 40.2%), while, again, Italy has the lowest proportion (at 1.0%).

The final descriptive trend examined, the proportion of the care workforce that is female, displays considerable convergence across regime types. In line with prior research documenting the highly feminized nature of work in health, education, and social work (e.g. Budig & Misra, 2010; Tungohan et al., 2015), females account for the majority of both high and low status care workers in all countries examined. In addition, the proportions are remarkably similar across welfare regimes, at approximately 68-69% of the high-status care workforce, and 83-86% of the low-status care workforce, on average. Thus, initial descriptive statistics evidence common trends in the care economies both across and within the three welfare regimes.

[Insert Table 1 here]

Who Cares? The Probability of Performing High and Low-Status Care Work

Tables 2 and 3 shift the analysis to who is engaged in high and low status care work within each country, again with the goal of examining similarities and/or differences across and within welfare regimes. For this analysis, binary logistic regressions are run. Logistic regression allows for examination of immigrant and gendered variation in care work, after statistically adjusting for family structure and demographic characteristics, as well as human capital. For these models, the dependent variables are a dichotomous measure of high or low-status care, coded as 1 for employment in high/low-status care work, with 0 denoting all other occupations. For convenience in interpreting the results, the predicted probabilities are presented for each

population group from the mean (e.g. their chances out of 100 of working in high status care).

Table 2 demonstrates that in eleven out of the twelve countries analyzed, immigrants are less likely to engage in high-status care work than comparable native-born populations, controlling for family structure, demographic characteristics, and human capital. These results bolster findings of high levels of social closure within professional occupations in health, social work and education (Barron & West, 2013; Weedon, 2002) (Author, 2018). This suggests that access barriers, perhaps due to foreign-acquired education or language skills, and/or discrimination, may be a major concern across the three welfare regimes. Notably, however, Ireland stands as a slight outlier, with immigrants having a marginally *higher* probability of working in high-status care than equivalent non-immigrant populations. This may be due to open borders in the European Union facilitating the flow of English-speaking professionals from poorer member countries as of 2010.

Table 2 also demonstrates that immigrants have the lowest probability of being high-status care workers in the Netherlands (at 0.9 chances out of 100) and the highest probability of working in high-status care in Denmark (at 5.0 chances out of 100), demonstrating considerable divergence within social democratic welfare regimes. At mean levels, the probability for immigrant employment in high status care is higher in conservative/continental welfare regimes (at 3.7 chances out of 100, on average) than liberal welfare regimes (at 2.5 chances out of 100, on average) but general trends are similar. In addition, women have at least twice as high probabilities of being in high-status care work as men within all countries analysed except Switzerland, where the reverse pattern is observed. Finally, as anticipated, individuals with a high level of education have by far the highest probability of working in high-status care in all twelve countries of analysis, reinforcing Weedson's (2002) suggestion that education is a means to enter occupations with high levels of social closure.

[Insert Table 2 here]

Compared to the high-status care workforce, Table 3 demonstrates greater variability in the probabilities of working in low status care. Overall, opposite trends for immigrants within low status care as compared to high status care are observed, reinforcing suggestions of the overrepresentation of migrant women in low paying service jobs in health, education and social work due to a globalized care economy (Hochschild, 2012; Parreñas, 2013). In nine out of the twelve countries examined, immigrants have a higher probability of working in low-status care than comparable non-immigrant populations, although the magnitude of difference is minimal in certain cases.

Immigrants have the highest probability of working in low-status care in Austria (at 10.7 chances out of 100), followed by Denmark (7.5 chances out of 100). Only in Canada and Spain do immigrants have a lower probability of working in low-status care than non-immigrants, controlling for demographic characteristics and human capital, with equal probabilities found in Germany. In addition, Table 3 demonstrates that in all cases women have considerably higher probabilities of working in low-status care than men (more than eight times higher in Australia) and that compared to high-status care work, individuals in low-status care work are more likely to have a low or medium level of education, hinting at lower wages and lower levels of social closure within these caring jobs.

[Insert Table 3 here]

Together, the logistic regressions in Tables 2 and 3 demonstrate a trend for immigrants across welfare regimes of a higher probability of employment in low-status care and a lower probability of employment in high-status care than equivalent non-immigrant populations, controlling for gender, demographic factors, and human capital. The following section provides the final empirical analysis, examining if immigrants incur an additional wage penalty in care work across and within welfare regimes and measuring the impact of national-level conditions, including welfare regime type, on care wages, using Ordinary Least Squares regression.

Care and Immigrant Wage Penalties Across Welfare Regimes

Table 4 displays results from four cumulative pooled country models to examine care wages in the total sample (N=44,414) and test the impact of national-level factors, and in particular, regime type. Here, the dependent variable is the natural log of annual earnings (including wages and self-employment income), with values standardized across countries to 2010 USD. Logged earnings have the benefit of normalizing the earnings distribution, as well as allowing the transformed regression coefficients to be interpreted as approximate percentage change in earnings for a one-unit change in the independent variable (Budig & Misra, 2010).

Model 1 includes the focal individual-level variables – employment in high/low status care work, immigrant status, and gender – as well as controls for age, marital status, the presence of young children, and level of education. Here, compared to non-care workers (the reference group), and in line with the previous findings at the single-country level, high status care workers have a 15% wage bonus and low status care workers incur a 10% wage penalty overall, suggesting, as anticipated, that all care work in not equal or equally valued. In addition to this, we see that immigrants, regardless of type of employment, incur a 4% wage penalty. A major gender divide is also evidenced, with a 41% wage penalty for being female, controlling for other factors. This disparity is likely explained, in part, by women's higher levels of part-time and precarious employment (Author, 2018).

Model 2 builds on Model 1, adding an interaction between immigrant status and high/low status care work. Here, the main effects demonstrate a continued care bonus for high status care (now, for non-immigrants, at 13%) and a care penalty in low status care work (again, at -10% for both immigrant and non-immigrants), as well as a 5% wage penalty for immigrants not working in care. Interestingly, however, the data demonstrate a significant and positive moderating effect of immigrant status on high status care work (leading to a wage bonus of 15%). This suggests that while immigrants in the vast majority of countries have a lower probability of working in high status care (as seen in Table 3), those who do work in professional jobs in health, education, and social work incur a minimal wage bonus (2% higher, on average) as compared to equivalent non-immigrants working in high status care. In the case of immigrants in low status care work, the interactive term is not significant, suggesting that the wage penalties are similar for immigrants and non-immigrants. Differently put, this suggests that wages for low status care are typically not different for immigrants than for non-immigrants populations, yet their probability of employment in these low paying jobs is substantially higher in the majority of countries.

Model 3 includes the country-level variables – welfare regime type (with liberal as the reference group), proportion of immigrants in the country, and the GINI coefficient to measure inequality. Examining the individual-level focal variables, the results suggest that the wage bonus for high status care for both non-immigrants and immigrants diminishes slightly (at 10% and 13% compared to non-care workers, respectively) with the inclusion of the country-level

variables. However, the wage penalty for low status care (for both immigrants and non-immigrants) and for immigrants working in non-caring occupations increases substantively (by 8% in both cases), suggesting a partial suppression effect. Thus, there is evidence that without the inclusion of national-level controls, the effects of care work and immigrant status on wages are somewhat obscured.

Model 3 also demonstrates that the effects of the national-level variables are substantive and robust. As anticipated in the literature, there is, on average, a significant wage bonus for being in a social democratic regime (compared to a liberal regime) (Ebbinghaus, 2012; Sabbagh & Vanhuysse, 2010). In the case of continental/conservative regimes, there is a significant wage penalty (as compared to being in a liberal regime). Thus, the ongoing relevance of welfare regimes on wages, independent of care work, are demonstrated. In addition, both the proportion of immigrants and the GINI coefficient are significant, demonstrating that controlling for the other factors, less equal countries have lower wages on average, and that countries with a higher proportion of immigrants have higher wages on average.

Finally, the results from Model 4, the final statistical model, include a country-level interaction between high and low status care work and welfare regime type, with results that are perhaps most relevant for the focal research questions. A significant and positive interaction is found between low status care and social democratic regime type suggest that being in a social democratic welfare regime compensates (and slightly reverses) the negative impact on wages of being in low status care. Thus, this is strong evidence that wage penalties in care work are not universal, and that welfare regimes *do* matter in the case of service and sales work in health, education and social work. In addition, with the impact of these country-level interactions, the wage penalty for low status care work almost doubles, again suggesting a suppression effect. Work in low status care, for both immigrants and non-immigrants, ultimately has a 34% wage penalty in liberal and continental welfare regimes, while the wage bonus for high status care remains slightly stronger for immigrants than non-immigrants (at 13% and 10% respectively).

[Insert Table 4 here]

Taken altogether, Table 4 demonstrates that welfare regime type matters in the case of low status care work. After controlling for individual characteristics and human capital, low-status care workers, both immigrant and non-immigrant, are significantly and substantively disadvantaged in terms of earnings in liberal and continental welfare regimes, with earnings that are roughly a third lower than equivalent workers in non-caring occupations. This bolsters prior findings of a low social value accorded to low-status care (Anderson, 2010) (Author 2017, 2018). However, this is not the case in social democratic regimes, where there is a positive moderating effect of working in low status care, relative to liberal welfare regimes. High status care workers, for their part, incur a wage bonus, controlling for regime type, again suggesting that high levels of social closure may lead to high wages in professional occupations in health, education, and social work, and this effect is slightly higher for immigrants than for non-immigrants. Yet, this final finding must be contextualized with immigrants' lower probability of working within these professional care work jobs in the majority of countries, independent of wages.

Conclusions

Since the introduction of Esping-Anderson's welfare regime typology in 1990 his method of classifying countries according to the relationship between state, market, and family has garnered widespread emulation, evaluation, and adaptation, as well as strident critiques (see, for example, Brennan et al., 2012; Ebbinghaus, 2012). However, prior to this study, Esping-Anderson's "regime approach" had not been applied in a quantitative cross-national comparative study of the labour market outcomes of migrant care workers. Thus, the present study provides an initial effort to address this gap, examining care work across and within twelve countries and three welfare regimes – liberal, conservative/continental and social democratic - with a particular focus on the employment and earnings of immigrant workers. This, done with an understanding of the various limitations of Esping-Anderson's methodology, is presented as a complement to the many rich qualitative analyses of the downward trajectories of migrant care workers, as well as in-depth single-country analyses documenting wage disparities in care (e.g. Folbre, 2012; Van Hooren, 2012).

Williams (2012), in her analysis of the intersecting care, migration, and employment regimes across European welfare states, suggests that due to the growing reliance on migrant women providing care for pay in wealthier countries, there is evidence of a transnational political economy of care. Yet, Williams also suggests that within individual countries, care provisioning is characterized by variation in policies and practices. Thus, Williams states that "the effect is an infinite diversity of migrant care work that seems to render generalization and cross-national comparisons difficult" (p. 365). Similarly, Mahon et al. (2012) suggest that due to the transnational spread of neoliberal ideas there has been convergence between social democratic and liberal regimes in the provision of child care, while Hay (2004) emphasizes that regional, rather than global, processes have led to convergence and integration across care economies.

Broadly, this study aims to provide an initial effort at empirically measuring the degree of care convergence and/or divergence across welfare regimes, with the rise of global care chains. Using twelve case study countries, I measure care wage bonuses and penalties across welfare regimes using Luxembourg Income Study data. Specifically, I measure if (female) immigrant workers more likely to work in low wage, low status care work than equivalent non-immigrant workers, regardless of welfare regime type, and assess the effect of welfare regime type on care work wages across countries.

Weeden's (2002) distinction between caring jobs with higher or lower social closure proves instructive. I distinguish between high and low-status caring occupations, as a proxy for jobs with greater and lesser social closure. Thus, rather than assuming that all care work is highly feminized, poorly paid and precarious, this classification scheme allows for measurement of differences between and within care employment across welfare regimes, as well as a specific focus on wage penalties in service and sales work in care. At the descriptive level, I find that social democratic welfare regimes have a larger proportion of their workforce employed in both high and low status care, supporting prior research on the ongoing investment in women's employment policies and larger public sector within such regimes (Aspalter, 2011; Beresford, 2016). In addition, in the majority of countries analyzed, there is a higher proportion of both immigrants and women working in low status care than in high status care, reinforcing prior findings of the highly feminized (and racialized) nature of caring occupations with low levels of social closure (Barron & West, 2013; Folbre, 2012).

The multivariate analyses demonstrate convergence across welfare regimes in term of *who* is doing the work of care. Immigrants, and women, across welfare regimes have a higher probability of employment in low-status care and a lower probability of employment in high-

status care than equivalent non-immigrant/male populations, controlling for demographic factors and human capital. However, divergence is seen in the analyses of wages for immigrants working in high and low status care across welfare regimes. In particular, social democratic welfare regimes compensate for (and slightly reverse) the negative impact on wages of being in low status care. Work in service and sales in health, education, and social work, for both immigrants and non-immigrants, has a 34% wage penalty in liberal and continental welfare regimes, controlling for both country and individual-level factors, but *not* in social democratic regimes. Thus, this is evidence that wage penalties in care work are not universal, and that welfare regimes *do* matter in the case of low status care work. Those immigrants and non-immigrants working in lower status caring jobs see their wage penalty entirely eliminated in social democratic regimes, reinforcing prior findings of the variation across regime type (e.g. Bradley et al., 2003; Huber et al., 2009).

Significantly, the wage bonus for high status care is found to be slightly *higher* for immigrants than non-immigrants (at 13% and 10% respectively), controlling for regime type. While immigrants may face access barriers to enter into professional jobs in health, education and social work across welfare regimes, this suggest that once they enter these occupations they are successful in terms of wages. Thus, the focus for social policies and practices ought to be on eliminating access barriers for immigrant into these jobs, and well as providing protections and employment supports for the overwhelmingly female (and immigrant) workforce in low-status caring occupations, with a particular focus on liberal and conservative welfare regimes.

Ultimately, findings from this article are meaningful in the current policy context. The data reinforce prior findings that countries that equalize access to care through providing and/or subsidizing provisioning in the public sector may reduce any wage penalty or even contribute to a care work premium for workers (Budig & Misra, 2010) (Author, 2017). Conversely, countries where care provisioning is largely through private markets may experience greater care work penalties and polarization, and a higher reliance on migrant and racialized women to provide low status, poorly paid care. Internationally, the contracting-out of domiciliary services, nursing, childcare and residential care to the private-for-profit sector has seen a worsening of working conditions and labour shortages, in addition to reduced quality of recipient care (Cangiano & Walsh, 2013) (Author, 2017). Thus, growing government austerity and earnings polarization across welfare regimes coincide with global shifts towards market-oriented care regimes that may disadvantage vulnerable immigrant workers, facilitate precarious working conditions for both immigrants and non-immigrants, with measurable effects on the quality of care received by vulnerable populations.

Endnotes

[1] This categorization is done with recognition of the considerable debate as to whether Italy and Spain should be categorized separately. Some scholars identify a "southern syndrome", based on the unique histories and processes of care provisioning in southern Europe (Calzada, 2018). Nonetheless, in an effort for parsimony, as well as due to limited data availability, Italy and Spain are included as conservative/continental regimes in the present analysis – justified by the forthcoming examination of diversity within as well as across welfare regime types, and the ongoing similarities identified within these countries in terms of a moderate level of decommodification and a high level of familialism (Ebbinghaus, 2012; Powell & Barrientos, 2011).

[2] For example, in Switzerland, there is ongoing debate as to whether the country fits best as a liberal or continental regime (Obinger et al. 2012).
[3] The immigration variable in the Canadian dataset only includes individuals who live in an urban area of 500,000 persons or more, excluding the experiences of migrant care workers in smaller locales.
[4] Though not reported in the tables, the mean percentage of immigrants within the liberal welfare regimes included (at 26.2%) is approximately twice as high as that for continental regimes (where the mean percentage of immigrant workers is 13.8%). The social democratic countries have by far the lowest mean levels of immigrant workers (at 10.1%).

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Table 1: Overview of the Care Economy, by Country (%)

	High Status Care Work			Low Status Care Work		
	% of Workforce	**% Immigrant**	**% Female**	**% of Workforce**	**% Immigrant**	**% Female**
Liberal Regimes (Mean)	**8.5**	**22.6**	**68.5**	**3.7**	**28.9**	**83.5**
AU	9.3	29.7	66.7	4.8	28.3	84.8
CA	7.2	20.7	70.5	2.3	35.4	75.7
CH	9.6	24.9	66.0	4.2	40.2	82.8
IE	8.4	25.5	71.1	4.2	20.2	89.7
US	7.9	12.0	68.1	3.4	20.5	84.4
Continental Regimes (Mean)	**7.8**	**8.0**	**68.3**	**3.1**	**10.3**	**84.4**
AT	8.1	9.0	68.1	3.0	20.7	82.5
DE	7.2	11.2	65.0	3.6	13.9	91.7
ES	9.2	3.0	68.0	2.1	6.6	88.2
FR	8.0	14.0	68.5	6.3	9.1	78.4
IT	6.6	3.0	71.9	0.5	1.0	81.2
Social Democratic Regimes (Mean)	**14.2**	**6.8**	**68.9**	**7.2**	**10.3**	**85.9**
DK	17.5	7.1	71.8	10.8	9.0	76.5
NL	10.9	6.4	65.9	3.6	11.5	95.2

Population is limited to individuals aged 18-64, who are employed and are not enrolled as full-time students and have earnings >$0.

Table 2: Chances out of 100 of Performing Professional (High Status) Paid Care Work by Country, 2010[a][b]

	LIBERAL REGIMES					CONTINENTAL REGIMES					SOCIAL DEMOCRATIC REGIMES	
	AU	**CA**	**CH**	**IL**	**US**	**AT**	**DE**	**ES**	**FR**	**IT**	**DK**	**NL**
Female	5.7	6.8	0.9	4.6	6.0	5.9	4.4	1.8	6.8	6.8	11.5	2.7
Male	2.4	2.5	1.8	1.5	2.5	2.7	1.9	0.3	3.0	2.1	3.6	1.1
Immigrants	2.9	2.7	1.3	2.7	3.0	1.5	2.6	0.2	2.6	1.0	5.0	0.9
Native-born	3.8	4.3	1.3	2.6	3.9	3.7	3.0	0.5	4.2	4.1	6.5	1.7
Low education	0.5	0.5	0.1	0.1	0.4	0.6	0.8	0.1	0.3	1.6	1.7	0.2
Medium Education	1.6	1.2	0.7	1.4	1.4	2.2	1.4	2.1	0.8	4.9	2.4	0.8
High Education	20.3	8.9	4.9	14.0	13.1	21.5	18.2	10.8	4.0	6.7	37.2	11.4

[a] Logistic regression results control for demographic characteristics (age, marital status/cohabitation, and the presence of young children in the household).

[b] Divided by 100 the product is a probability

Population is limited to individuals aged 18-64, who are employed and are not enrolled as full-time students and have earnings >$0.

Table 3: Chances out of 100 of Performing Service and Sales (Low Status) Paid Care Work by Country[a][b]

	LIBERAL REGIMES					CONTINENTAL REGIMES					SOCIAL DEMOCRATIC REGIMES	
	AU	**CA**	**CH**	**IL**	**US**	**AT**	**DE**	**ES**	**FR**	**IT**	**DK**	**NL**
Female	8.6	3.5	4.8	7.2	5.3	4.2	5.0	3.5	2.4	3.1	12.9	3.0
Male	1.1	0.9	1.1	0.6	0.6	0.8	0.5	0.3	0.5	0.4	3.2	0.9
Immigrants	3.0	1.6	2.5	3.2	2.1	10.7	1.6	0.6	2.0	0.7	7.5	1.5
Native-born	2.7	1.8	2.1	1.9	1.6	1.7	1.6	1.2	1.4	0.5	6.4	1.4
Low education	2.1	3.0	3.2	4.6	3.4	2.0	2.4	1.0	1.6	1.4	9.5	0.8
Medium Education	4.5	2.1	3.1	3.2	2.7	2.2	2.3	2.2	0.7	0.3	12.3	1.8
High Education	2.1	1.5	1.2	1.2	0.9	0.7	0.7	0.6	0.1	1.1	2.1	0.2

[a] Logistic regression results control for demographic characteristics (age, marital status/cohabitation, and the presence of young children in the household).

[b] Divided by 100 the product is a probability

Population is limited to individuals aged 18-64, who are employed and are not enrolled as full-time students and have earnings >$0.

Table 4: Pooled Cumulative Ordered Models Predicting Logged Earnings

	Model 1		Model 2		Model 3		Model 4	
	Coefficient	*S.E.*	*Coefficient*	*S.E.*	*Coefficient*	*S.E.*	*Coefficient*	*S.E.*
Intercept	8.57***	(0.05)	8.57***	(0.05)	8.05***	(0.08)	8.1***	(0.08)
Focal Ind.-level variables								
Care Effect (ref = non-care employment)								
High Status	0.15***	(0.02)	0.13***	(0.02)	0.10***	(0.02)	0.10***	(0.02
Low Status	-0.10**	(0.02)	-0.10**	(0.02)	-0.18**	(0.02)	-0.34***	(0.03)
Immigrant Status (ref = non-immigrant)	-0.04***	(0.01)	-0.05***	(0.01)	-0.13***	(0.01)	-0.14***	(0.01)
Female (ref = male)	-0.41***	(0.01)	-0.41***	(0.01)	-0.41***	(0.01)	-0.42***	(0.01)
Ind-level interaction								
Immigrant*High status care	--	--	0.15***	(0.04)	0.13**	(0.04)	0.13**	(0.04)
Immigrant*Low status care	--	--	-0.03	(0.05)	-0.02	(0.05)	0.06	(0.05)
Ind.-level control variables								
Age	0.10***	(0.01)	0.10***	(0.01)	0.12***	(0.01)	0.12***	(0.01)
Age Squared	-0.001***	(0.00)	-0.001***	(0.00)	-0.001***	(0.00)	-0.001***	(0.00)
Married or Cohabitating (ref = single/widowed/divorced)	0.06***	(0.01)	0.06***	(0.01)	0.06***	(0.01)	0.06***	(0.01)
Living with child 0-5 years	0.004	(0.01)	0.004	(0.01)	-0.01	(0.01)	-0.01	(0.01)

(ref = other)								
Education level (ref = high)								
Low	-0.72***	(0.01)	-0.71***	(0.01)	-0.65***	(0.01)	-0.65***	(0.01)
Medium	-0.37***	(0.01)	-0.37***	(0.01)	-0.34***	(0.02)	-0.34***	(0.02)
Country-level variables								
Welfare regime (ref = Liberal)								
Continental	--	--	--	--	-0.27***	(0.01)	-0.27***	(0.01)
Social Democratic	--	--	--	--	0.39***	(0.02)	0.37***	(0.02)
Proportion Immigrants	--	--	--	--	0.03**	(0.01)	0.03**	(0.01)
GINI coefficient	--	--	--	--	-0.06**	(0.01)	-0.06**	(0.01)
Country-level interaction								
Continental*High status care	--	--	--	--	--	--	0.02	(0.03)
Continental*Low status care	--	--	--	--	--	--	0.09	(0.05)
Social Democratic*High status care	--	--	--	--	--	--	-0.01	(0.03)
Social Democratic*Low status care	--	--	--	--	--	--	0.39***	(0.04)
Statistical Fit								
Adjusted R Square.	0.21		0.21		0.28		0.31	
n (Countries)	12							
N (Individuals)	44,414							

Appendix 1: Details of Care Work Classification Scheme, Luxembourg Income Study, 2010

Country, Sample Size, Dataset	**Care Industries & Occupations** (derived from the International Standard Classification of Occupations (ISCO-08), and the LIS standardized industry variable)	
Australia (AU) (N=16,770) *Household Expenditure Survey (HES) and Survey of Income and Housing (HIS)* Austria (AT) (N= 3,998) *Survey on Income and Living Conditions (SILC)* Canada (CA) (N = 26,310) *Survey of Labour and Income Dynamics* Denmark (DK) (N= 3,943) *Law Model* (based on administrative records) France (FR) (N= 1,338) *Household Budget Survey (BdF)* Germany (DE) (N=3,953) *German Socio-Economic Panel (GSOEP)* Ireland (IL) (N= 3,219) *Survey of Income and Living Conditions* Italy (IT) (N=3,071) *Survey of Household Income and Wealth (SHIW)* Netherlands (NL) (N=2,131) *Survey of Income and Living Conditions (SILC)* Spain (ES) (N=3,659) *Survey of Income and Living Conditions (SILC)* Switzerland (CH) (N=7,193) *Survey on Income and Living Conditions*	***Professional (High Status) Jobs in Care Work***	
	Education University and Higher Education Teachers; Vocational Education Teachers; Secondary Education Teachers; Primary School and Early Childhood Teachers; Other Teaching Professionals (e.g. Language Teachers, Special Needs Teachers, Information Technology Trainers)	*Health* Medical Doctors – General and Specialist; Nursing and Midwifery Professionals; Traditional and Complementary Medicine Professionals; Paramedical Practitioners; Veterinarians, Other Health Professionals (e.g. Dentists, Pharmacists, Physiotherapists, Dieticians, Speech Therapists)
	Service and Sales Worker (Low Status) Jobs in Care Work	
	Education Child Care Workers; Babysitters; Nannies; Teachers' Aides	*Health* Personal Care Workers in Health Services; Health Care Assistants; Birth Assistants; Psychiatric Aides; Home-Based Personal Care Workers; Dental Aides; Hospital Orderlies; Pharmacy Aides; First Aid Attendants

United States (US) (N= 46,875) *Current Population Survey – ASEC (Annual Social and Economic Supplement)*		

Population is limited to individuals aged 18-64, who are employed and are not enrolled as full-time students.
Adapted from Author (2018).