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Migrant care workers in Swedish elderly and disability care: Are they disadvantaged?

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ABSTRACT

The present study outlines characteristics among migrant care workers in elderly and disability care in Sweden. The aim of the study was to investigate whether migrant care workers perceive their situation at work as more problematic than their native peers. The study was based on the Nordcare dataset, an extensive mail survey aimed at investigating conditions among care workers in the Nordic countries (n=735 in the Swedish part of the dataset). Care workers born outside Sweden constituted 13 per cent (n=94) of the workforce. When taking other variables into account, the situation of migrant care workers from other Nordic countries was similar to that of Swedish-born care workers. Being born outside the Nordic countries was associated with an increased risk of having a high work load and not being appreciated by co-workers, and a decreased risk of being criticized by care users. Male care workers born outside the Nordic displayed aspects of precariousness that merits further investigation. Based on these findings, researchers and policy makers are warned not to presume that all migrant care workers suffer from precarious working conditions and that such conditions reported by members of the category may be attributed to other factors than ethnic origin.

Keywords:

Elderly care, discrimination, disability care, migration, migrant care workers, racism, precarious work

Migrant care workers in Swedish elderly and disability care: Are they disadvantaged?

Are immigrants working in elderly and disability care worse off than their native-born peers? Do they perceive their situation at work as particularly precarious? Do they feel less appreciated by managers and co-workers and encounter racial prejudice and criticism from care users to a greater extent than their native peers? These questions are relevant to pose in light of the present interest devoted to the *category of migrant care workers*. Several studies have shown that migrant care workers suffer from exploitation, subordination and discrimination (Olsson 1995; Datta et al., 2006; Coyle, 2007; Storm, 2008; Simonazzi, 2009; Lill 2007; Cangiano et al., 2009; Walsh & O'Shea, 2009).

While there is reason to devote interest to migrant care workers, there is also a risk that members of this category are regarded as essentially different from native-born care workers. *Typification* is an inherent aspect of *categorization*, implying that (stereo)typical images and events come to mind when a particular category is discussed (Loseke, 2003). Much of the discussion among researchers in Europe has focussed on women from countries in Asia, Africa and the former socialist countries coming to work in low-paid care (Kröger & Zechner, 2009). There is a tendency to inscribe certain scenarios in the understanding of who migrant care workers are and what conditions they encounter. Simonazzi (2008:225) identifies two types of immigrants working in care: those who have migrated to engage in care work and those who have “ended up in the care sector since this was the only work that the person could find.” Ideal-type scenarios risk bringing precariousness into the very definition of being an immigrant, but empirical findings suggest that some migrant care workers have a positive view of their working conditions (Doyle & Timonen, 2009). In addition, it is not uncommon that immigrants are interviewed about precarious working conditions and the problems they report are regarded as proof of discrimination (McKay, Craw and Chopra, 2006; Walsh & O'Shea, 2009; Agudelo-Suárez et al. 2009). Given the existing framework of typifications and the lack of comparison with native-born care workers, this methodology may direct too much attention towards ethnicity and descent, thus diverting interest from differences that relate to aspects such as age, gender, education and the organization of care within different welfare systems.

The aim of the present study is not to refute the suggestion that many migrant care workers suffer from precarious working conditions, but to highlight the relative importance of being an immigrant and a care worker in a country like Sweden where care work is formalized and regulated. In contrast to

previous studies on migrant care workers, we apply a quantitative and comparative design: care workers born outside Sweden are compared with native-born care workers. Some studies indicate that problems like prejudice and discrimination are rooted in the informal working conditions that some migrant care workers encounter (Doyle & Timonen, 2009; Porthé et al. 2010). In a European perspective the provision of care in Sweden is regulated and embedded in the social security system. It is thus possible to test the hypothesis that within a workforce that is relatively established, migrant care workers do not perceive their working situation as worse than their native-born peers.

Following the comparative approach, we will discuss findings in terms of discrimination. According to Collins Dictionary of Sociology (Jary & Jary, 1995:169), discrimination refers to “the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group.” Previous studies have used discrimination as a way of contextualizing precarious working conditions and perceived social relations: complaints from care users, relationships with managers and co-workers (McKay, Craw & Chopra, 2006; Cangiano et al., 2009; Walsh & O’Shea, 2009; Agudelo-Suárez et al. 2009). As in other European countries, the discrimination act of Sweden relates the concept of discrimination to the occurrence of a “comparable situation”. A comparative quantitative study has the capacity to “parallel” this approach to discrimination, through the use of a multivariate analysis that includes variables indicating the presence and absence of comparability (for instance age, education and workplace). This is not to suggest that our study can identify or rule out discrimination in the legal sense. The essence of discrimination is difficult to capture, and interpretations on the individual level are dependent on existing frameworks for interpretation (Loseke, 2003).

Migration in Sweden

The phenomenon of migrant care workers needs to be understood from perspectives of care regimes as well as patterns of migration (Simonazzi, 2009). The immigrant population in Sweden is obviously not a homogeneous category; beyond the individual level differences among subcategories relate to country/region of origin, reason for migration and time spent in the new country. For many years people have been allowed to move freely between Nordic countries, and this is reflected in the care sector where a significant number of the employees come from Finland. During the years of economic growth in the 1950s and 60s, people from neighbouring countries migrated to Sweden to work in heavy industry, and Swedish companies also recruited labour from countries such as Greece, Italy and Yugoslavia. While migration between Nordic countries has continued, most immigrants arriving in Sweden since the 1970s have been asylum seekers (including cases of family reunification). Sweden

has 9 million residents, and in 2007 13.3 per cent of these were born outside the country. At present, the largest groups of immigrants residing in Sweden come from Finland, followed by Iraq, (former) Yugoslavia and Iran.

The general situation of immigrants on the Swedish labour market has been described as precarious regarding aspects such as access, job security and status (Hjerm, 2002; Ekberg & Roth, 2004; SOU 2004:73). OECD statistics show that the difference regarding degree of employment between native and non-native residents of Sweden is comparatively high: 20 per cent in 1995 and 12 per cent in 2009. Swedish officials claim that differences are explained by the high employment rate among Swedish-born women, the absence of labour force migration, and the fact that many immigrants are refugees that have arrived during the last years (Ds 2011:17).

In comparison to other European countries, the state (municipalities) has a dominant role in the provision of care. Although recent years have been characterized by an increased informalization and privatization, the public sector is the main financer, provider and employer (Lyon & Glucksman, 2008). Care workers in Sweden have “relatively good employment conditions” (Simonazzi, 2009:222); wages and the level of education are among the highest in Europe. In 2008, 14 per cent of care workers in elderly care and disability care were estimated to have been born outside the country, compared to 10 per cent in 1998 (SCB, 2010).

Dataset

In this study, the term migrant care worker refers to persons born outside Sweden who work in Swedish elderly or disability care. The study is based on the Nordcare dataset (Szebehely & Trydegård, 2007; Armstrong et al., 2009). Nordcare is a dataset with extensive information on everyday work and conditions of workers in elderly care in the four Nordic countries Denmark, Finland, Norway and Sweden. The Nordcare survey was mailed to 4950 care workers (home helpers, care aides and assistant nurses within elderly care, personal assistants within disability care), randomly selected among members of unions that organize workers in elderly care (in Sweden the union “Kommunal”). Data collection took place between February and April 2005 by letter to the respondent’s home address, with two reminders in the event of non-response. The Swedish net sample consisted of 1103 persons of who 735 answered the survey, resulting in a response rate of 66.6%. The response rates were slightly higher in the other Nordic countries, with a mean of 72.4% for all countries.

Using registers from unions was regarded as a way of increasing participation in the study. A limitation of the study is that the degree of unionization is lower among those care workers who are most likely to suffer from precarious working conditions and migrant care workers are likely to be overrepresented in this group (SOU 2001:79; Homme & Høst, 2008). Nordic countries have a very high union membership rate; in 2006 the degree of unionization among publicly/privately employed workers born outside Sweden was 85/75 per cent as compared to 87/74 per cent among Swedish-born workers (Kjellberg, 2010).

It is likely that the ability to deal with an extensive mail survey affected participation in the Nordcare study and that precarious working conditions are more prevalent among migrant care workers who struggle with the Swedish language. For these reasons the conclusions of the study are limited to an *established* workforce in formal elder care.

The Nordcare survey captured care workers in public as well as private employment. The survey is restricted to formal care workers but there is also an informal market for services in Sweden. The Swedish system of elderly care can be described as highly regulated and dominated by paid work using the concepts of Ungerson (2004). According to the Swedish Tax Agency (Skatteverket 2006), non-reported work income is estimated at about ten percent of total income from work and widespread in restaurants, taxi and cleaning but limited in personal services. Elderly care is distributed as a service (or vouchers in some cases) by the municipalities of Sweden and not as cash for care. There is an informal market for cleaning services but informal services are less expensive for the caretaker only when need is limited or occasional. Informal work seems to be of marginal scope regarding body care, except unpaid work by relatives.

Ethical considerations

In the request to participate, respondents were informed that the purpose of the study was to investigate conditions of Nordic care workers and that participation was voluntary. Personal information such as name and identifying code was removed when questionnaires were registered in the dataset. The authors of this study received the anonymized dataset.

The proportion of migrant care workers

Of the total of 2989 respondents who answered the question on country of birth, only 177 were immigrants, or 5.6 per cent. There were large differences between countries, which partially reflect the proportion of immigrants in the general population.

Table 1. Native and migrant care workers in the Nordic countries.

Country	Native		Immigrant	
	n	%	n	%
Denmark	795	96	36	4
Finland	716	99	6	1
Norway	853	95	41	5
Sweden	626	87	94	13
Total	2990	94	177	6

Note: Missing values on country of birth: 41.

The amount of foreign-born care workers in the Swedish part of the Nordcare dataset corresponds exactly to statistics from the Swedish Association of Legal Authorities and Regions for 2005 (SKL, 2006). The total amount of foreign-born employees in Sweden was 12.4 per cent in 2005 (Kjellberg, 2010).

Since the amount of migrant care workers differed substantially among Nordic countries, we have chosen to devote the analysis in the rest of this manuscript to the situation of Sweden, with some comparisons to the Nordic dataset.

In the Swedish dataset, 86 of the 94 participants born outside Sweden specified their country (or in some cases region of the world) of birth. Among them, immigrants from other Nordic countries constituted 36 per cent (n=31), immigrants from other European countries 21 per cent (n=18), immigrants from Asian countries 24 per cent (n=21), immigrants from African countries 10 per cent (n=9) and care workers from North and South America 9 per cent (n=8). One country was particularly represented as a “supplier” of migrant care workers in Sweden: 22 care workers were born in Finland, followed by Norway (n=7) and Bosnia (n=5).

Education, occupation and location of migrant care workers

The differences in level of *education* were small and insignificant between native and migrant care workers. More than 70 per cent of the respondents in the Swedish sample had at least one year of formal training in care work.

Formal care occurs in different settings: as home care where a number of users are served at home as well as in different types of residential care for elderly or disabled people. The only notable difference concerned personal assistance. Personal assistants provide an extensive and highly individualized support in daily living for one or a few severely disabled care users, primarily below the age of 65 (Clevnert & Johansson, 2010). Assistants are usually employed by agencies (municipal, private, cooperatives), but three per cent of service users act as independent employers. It is possible to employ relatives as personal assistants. It was considerably more common for immigrants than natives to work as *personal assistants*; 17 per cent of immigrants (20 per cent of immigrants born outside the Nordic countries) worked as personal assistants as compared to 10 per cent among Swedish-born care workers.

Thirty per cent of the care workers in the three big cities of Sweden were born outside the country, as compared to 9–10 per cent in rural areas and small cities. As regards the regional distribution of migrant care workers, 44 per cent were employed in the big cities compared to 16% of the native care workers. To some extent, but not entirely, this mirrors the general distribution of the population. Studies of migrant care workers are therefore sensitive to selection: a high proportion of immigrants can be expected if the sample is drawn in densely populated regions. Simonazzi (2009) suggests that migrant care workers still play a minor role in Sweden, but as is evident in our study this is not true for the larger cities of Sweden. The tendency for migrant care workers to concentrate in larger cities is known from Norwegian and British studies (Homme & Høst, 2008; Cangiano et al., 2009), as well as recent Swedish statistics (SCB, 2010).

Gender, age and time at work

A vast majority of care workers in Nordic elderly care are women. Elderly care in Sweden was least unisexual, with 7 per cent men, while the figures were 2 per cent for Finland and Norway and 5 per cent for Denmark. In the Swedish dataset, all respondents who were born in another Nordic country

were women. The proportion of men among immigrants from non-Nordic countries was 18 per cent. The picture was very similar in the Nordic dataset, where only one of 62 respondents born in another Nordic country was a man.

The mean age of the responding native care workers was 44.2 years. Migrant care workers from Nordic countries were older (48.6 years) than natives, while immigrants from non-Nordic countries were younger (39.4 years) than natives. The age distribution in the Nordic dataset is similar to the Swedish one, although the difference according to immigration is less accentuated. A possible interpretation is that age differences represent varying patterns of migration and careers of working life. This interpretation is supported by the fact that care workers born outside the Nordic countries also had the shortest experience of care work. In the Swedish dataset, 54 per cent of the non-Nordic immigrants had worked five years or less, compared to 19 per cent for natives and 20 per cent for immigrants from the Nordic countries. A further examination of the data points to the existence of a group of relatively old Finnish-born women who have worked for a long time in elderly care – and probably arrived during an immigration wave from Finland some decades ago. In this sense, the distribution of gender and age among subcategories of migrant care workers can be coupled to immigration waves and labour market opportunities. A British study found similar differences in the distribution of age when using a division between UK-born, recent and non-recent migrant care workers (Cangiano et al., 2009). The risk made visible here is that aspects relating to being a recent or non-recent immigrant are confused with aspects relating to origin and ethnicity.

Investigating discrimination

Do migrant care workers suffer from discrimination in the sense that they perceive their working conditions as more problematic than their native-born peers?

Thirteen variables indicating work related problems were chosen to investigate the presence of discrimination. Many of the indicators are indirect in the sense that they do not measure discrimination in itself; in this study they are used to indicate general inequalities not attributed to factors such as age, education and occupational category. Following previous research on precarious employment and discrimination (McNamara, Bohle & Quinlan, 2010; Porthé et al. 2010) variables were selected to investigate difference relating to job insecurity (V1), health (V2) control/empowerment (V7), and work-life conflict (V6). Variables capturing strain, lack of comprehension and dissatisfaction were included to highlight specific problems relating to human service organizations (V4, V5, V8) (Söderfeldt et al, 1996). Variables aiming at measuring social relations and conflict at the workplace

were included in accordance with previous research on discrimination affecting migrant care workers (Cangiano et al., 2009; Walsh & O'Shea, 2009; Doyle & Timonen, 2009). The model used to indicate discrimination in this study includes variables expressing a reported lack of support from managers (V9), appreciation from co-workers (V10) and care users (V11), as well as criticism (V12) and ethnic prejudice (V13) from care users or their relatives. A limitation of the Nordcare survey is that it did not include questions on income and social benefits. The study is limited to those comparisons that are conducted in the model.

Variables were dichotomized to be used as dummy variables in logistic regression. Below, variables that were selected as indicators will be presented with the value that indicates a negative condition. Most variables express personal experience, while a few are based on statements about objective conditions such as prevalence of sickness leave and type of formal employment contract. The chosen variables were dichotomized, in cases where they initially had more than two values. This operation was guided by theoretical rather than statistical considerations, and for this reason the total percentage of answers indicating precariousness differs substantially among variables.

Included in the index is the total percentage of care workers displaying problematic conditions on each variable (V1–V13).

Precarious working conditions

1. Insecure employment (14%).
2. Sickness leave more than once a year (54%).
3. Low rating on “interesting work tasks” (28%).
4. High rating on “too much work to do” (31%).
5. High rating on “feelings of insufficiency in relation to the needs of the care user” (24%).
6. High rating on “problems getting work, free time and family to match” (29%).
7. Low rating on “influence” (55%).
8. High rating on “considered leaving the job” (39%).

Problematic relations

9. Low rating on “support from manager” (62%).
10. Low rating on “appreciated by co-workers” (61%).

11. Low rating on “appreciated by care users” (44%).
12. High rating on “criticized by care users and relatives” (66%).
13. High rating on “experience of ethnic prejudice (racist/xenophobic comments) from care users and relatives” (30%).

Are migrant care workers worse off?

The model was used in two analyses: the first comparing migrant and Swedish-born care workers and the second distinguishing between Nordic and non-Nordic immigrants. Only the second analysis will be presented and discussed. Theoretically, a subdivision was based on the presumption that Nordic immigrants come from countries with a history of close political and social contacts with Sweden, with similar welfare systems, and the languages are similar enough to be understandable across nations (except Finnish). Empirically, an exploratory analysis showed that Nordic and non-Nordic immigrants were heterogeneous groups.

Results from the logistic regressions are presented for Nordic and non-Nordic immigrants with natives as the reference group in table 2. The left columns of table 2 shows the risk of migrant care workers compared to native care workers as a result of bivariate logistic regressions (with the problem-indicator as the dependent variable and immigration status as the independent variable). This analysis describes the difference of risk between migrant and native care workers in the sample. However, the difference in risk can be explained by the condition of being an immigrant as well as other factors. The right columns show the results of multivariate logistic regressions with compensation for the heterogeneity of groups. The control variables are gender, age, education, number of years in the occupation, occupational category and an indicator variable for working in a big city.

Table 2: Work related problems. Risk of immigrant care workers from another Nordic county and a non-Nordic country compared to native care workers (as reference level) in Sweden.

Indicator of work related problems	Immigrant from other Nordic country - bivariate analysis	Immigrant from other Nordic country - control for	Immigrant from non- Nordic country - bivariate analysis	Immigrant from non- Nordic country - control for
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		heterogeneity		heterogeneity
	Exp(B), (Sig.)	Exp(B), (Sig.)	Exp(B), (Sig.)	Exp(B), (Sig.)
Temporary employment	1.104, (.809)	.982, (.978)	1.832, (.020)	.813, (.673)
Sick leave	1.350, (.268)	1.423, (.369)	.974, (.895)	.809, (.543)
Work tasks uninteresting	2.288, (.172)	1.885, (.105)	1.656, (.336)	.928, (.838)
High work load	1.581, (.077)	1.454, (.347)	1.837, (.002)	3.348, (.001)
Feeling of insufficiency	1.247, (.444)	1.184, (.687)	.932, (.764)	1.390, (.395)
Incompatibility of work time and family and social life.	1.117, (.714)	.957, (.920)	1.557, (.040)	1.731, (0.118)
Low influence on work conditions	.912, (.723)	.683, (.309)	1.903, (.002)	1.350, (.397)
Low support from manager	.814, (.422)	.561, (.123)	1.034, (.864)	.907, (.785)
Not appreciated by colleagues	1.083, (.824)	.853, (.676)	1.705, (.089)	2.216, (.042)
Not appreciated by care user	1.116, (.673)	.939, (.870)	1.215, (.326)	1.286, (.465)
Criticized by care user	.734, (.285)	.810, (.597)	.529, (.002)	.408, (.014)
Experience of ethnic prejudice	1.167, (.561)	2.107, (.071)	1.657, (.010)	1.562, (.219)
Considered to leave the job	1.545, (0.97)	2.085, (.058)	.903, (.631)	.705, (.320)

Note: Logistic regression, statistically significant results ($p < .05$) in bold face.

Nordic immigrants did not differ in relation to the reference group, and non-Nordic immigrants differed significantly in only three of thirteen comparisons in the analyses with control for heterogeneity. In some cases, risk estimates were quite low or high without being statistically significant. This can be explained mainly by the low number of cases and the number of variables entered in the multivariate analyses, both leading to high standard errors in the estimation and possible type-II errors (real differences do not become statistically significant). The variability of the non-

significant estimates can mostly be attributed to large standard errors and should be interpreted very cautiously. Our discussion below will primarily deal with the significant estimates.

While the risk of not feeling appreciated by co-workers was quite high among all categories of care workers (61 per cent), this risk was twice as high among non-Nordic immigrants as among natives. The result corresponds with studies that report on feelings of subordination among migrant care workers and conflicts that are perceived in terms of ethnic relations (Olsson, 1995; Lill, 2007).

The greatest difference was related to how workload was experienced; the risk of experiencing a high workload was 3.3 times higher for non-Nordic immigrants compared to natives. The risk estimate was lower when analysed without control for heterogeneity, mostly because the proportion of personal assistance differed between immigrants and natives, and the experience of a lower workload in personal assistance. The experience of a high workload was almost ten times more common in elderly care than in personal assistance. The experience of a high workload among non-Nordic immigrants could be an effect of difficulties in combining work and family life and stronger responsibility for household work and care of relatives. However, differences in relation to natives were only minor in relation to these aspects. Despite testing a number of possible explanations we failed to match the differences in the experienced workload to other factors. A possibility is that migrant care workers feel that they have to prove their value by working harder than native-born staff (Lill, 2007). It could be speculated that the result is connected to the increased risk of not being appreciated by co-workers (and the decreased risk of being criticized by care users). Additional quantitative analysis of the present dataset did not further the understanding of this problem, and a qualitative study seems to be a better strategy for further research.

The origin of the care worker was *not* the strongest predictor of precariousness in any case. In most analyses, age and occupational category (elderly care or disability care vs. personal assistant) were the strongest predictors of problems associated with work. In some cases, gender was connected to precariousness, with higher risks for men.

Ethnic prejudice and criticism from care users

It is not uncommon that care users and relatives make racist remarks or refuse to be cared for by staff of foreign origin (Jönson, 2007; Storm, 2008; Walsh & O'Shea, 2009; Doyle & Timonen, 2009). The relatively small differences in our study are therefore surprising. When brought together as one category migrant care workers experienced an increased risk (1.8, $p = .044$) but the best predictors of being exposed to ethnic prejudice were the care worker's age and working in elderly care or disability

care (and not as a personal assistant in disability care). The risk of encountering ethnic prejudice was five times higher in the youngest group (< 30 years) compared to the oldest (> 50 years) and five times higher for staff working in elderly care or disability care compared to personal assistance.

Since gender and ethnicity interacted in the logistic regression, specific combinations of gender and ethnicity were analysed separately. Age, education, number of years in the occupation, occupational category and working in a big city were used as control variables.

In the analysis of the experience of prejudice, the risk was increased almost five times for men of non-Nordic origin ($p = .060$) and by two times for women born in other Nordic countries ($p = .083$). Differences were not significant but this could possibly be due to the small number of individuals. There was no significant difference for women of non-Nordic origin, and less surprisingly for men born in Sweden (Swedish-born women was the reference group in the analysis). Men of non-Nordic origin differ from the stereotype of a Swedish woman as the norm in care work regarding gender as well as ethnicity (Storm, 2008). However, the risk for women born in another Nordic country was greater than for women of non-Nordic origin, which does not comply with an explanation where ethnic prejudice is directly related to ethnic and geographical distance. A possible interpretation is that care workers from Finland are perceived and treated as “foreigners” among Swedish care users. Unlike other Nordic immigrants in Sweden, people from Finland are often discussed in terms of difference in culture and ethnicity (Heikkilä, 1996).

Care workers born outside the Nordic countries experienced less criticism from care users than natives; the risk was less than half of the risk for care workers born in Sweden. There was no difference between Nordic immigrants and natives, indicating that they are more similar in being exposed to or interpreting criticism. As with other problem variables, age was the most influential factor and young care workers had a relative risk of 3.3 ($p < .001$). The multivariate analysis of experience of criticism from care users and their relatives was performed with the same control variables as above. Here, only one group differed significantly: women of non-Nordic origin had a substantially lower risk of criticism, a relative risk of 0.33 ($p = .004$). Men of non-Nordic origin had an expected risk that was more than twice the risk of Swedish-born women, but the difference was not statistically significant. Interpretations are difficult to make, as we have no knowledge about the care users' views and actions. Are women born outside the Nordic countries actually much less criticized than natives or is it a matter of perception?

Do different indicators of discrimination add up?

The presentation has thus far been directed to single indicators of discrimination that have been discussed independently. From the individual's point of view, added vulnerability is important. There was great variation between respondents on the thirteen indicators, with the total sum varying between 0 and 13 among care workers in the Swedish sample, reflecting differing working conditions and varying ways to interpret, evaluate and adapt to these conditions. The experience of multiple problems associated with work was common, reflecting that care work is in itself associated with a problematic situation.

Table 3. Sum of problem indicators for Swedish care workers.

Number of problem variables	Number of respondents	Per cent
0–3	201	27.4
4–7	372	50.6
8–11	158	21.5
12–13	4	0.5
Total	735	100.0

Bearing the great variation in mind, the next question is how the sum of indicators is related to immigration. For women, migrant care workers had slightly higher mean values compared to natives but the difference was not statistically significant. The difference between native male and female care workers was very small and insignificant. The only group that differed markedly was male care workers born outside the Nordic countries. This group had a mean of 7.40 indicators compared to 5.24 for men born in Sweden, and the difference between men was statistically significant at the 5% level. A possible explanation for this result is that male immigrants perceive themselves as feminized when being forced to work in care (Dyer, et al. 2008). In summary, the only group that deviated substantially was men born in non-Nordic countries, but this was a very small group that only comprised about a half per cent of the sample.

Table 4. Sum of problem indicators by gender and origin of birth.

Gender	Country of birth	Mean	N	Std. deviation
Women	Sweden	5.32	586	2.585
	Nordic	5.66	35	2.754
	Non-Nordic	5.64	45	2.773
	Total	5.36	666	2.605
Men	Sweden	5.24	38	2.823
	Non-Nordic	7.40 *	10	2.319
	Total	5.69	48	2.845
Total	Sweden	5.31	624	2.598
	Nordic	5.66	35	2.754
	Non-Nordic	5.96	55	2.762
	Total	5.38	714	2.621

Note: *p=.031 compared to Swedish born men with t-test.

Migrant care workers – a category suffering from discrimination?

The main result of the study is the absence of differences regarding perceived work-related problems between native and migrant care workers that participated in the Nordcare survey. While many care workers reported having problematic working conditions, migrant care workers as a category did not stand out as disadvantaged in general. Given our main finding, it is important to note that migrant care workers born outside the Nordic countries reported having a high workload and being less appreciated by their workmates. These findings may express perceived subordination, making it relevant to pursue studies on possible discrimination. The analysis also indicates that male care workers of non-Nordic origin may have a precarious situation. These differences deserve further attention.

The study highlights a need to take other characteristics than ethnicity and migration into account when analysing precariousness among migrant care workers. The variation between individuals was much larger than the variation between immigrants and natives, and *age* (being under 30) was by far the most relevant predictor of a problematic situation at work. Our results support the initial warning that qualitative studies investigating the situation of migrant care workers run a risk of confusing hardship associated with gender, age and occupational category with hardship associated with migration or ethnicity.

It is important to discuss the absence of difference between care workers of different origin in relation to the limitations of our study. The analysis was based on self-reported information and it is known

that members of disadvantaged groups may avoid commenting on problems related to discrimination (Carney, Banaji & Krieger, 2010). The Nordcare survey did not capture potential differences in income and social benefits. The dataset tends to capture the situation of “established” care workers. Even so, when discussing different models within a European context it is important to acknowledge the existence of a comparatively well-established force of migrant care workers in Sweden. Sweden and other Nordic countries do not represent the diversity of care models in Europe, but still our result should act as a warning against constructing the entire category of migrant care workers in terms of precariousness, exploitation and discrimination. Regarding the category of *elderly immigrants* Torres (2006) suggests that despite frequent statements about diversity Swedish officials and researchers have presented the category as “problematic others” with special problems and needs. Our study shows that difference in relation to native-born care workers must not be taken for granted in studies of migrant care workers. People move between countries for different reasons and it is likely that many immigrants start working in care for similar reasons as natives (cf. Doyle & Timonen, 2009).

The organization of care work

Although our study does not contain comparisons to other sectors, it is striking that a high proportion of the respondents experienced trouble at work: 5.4 problem variables out of 13 as a mean. Several studies suggest that care work is comparatively unattractive and linked to precarious working conditions (Szebehely, 2005; Armstrong et al., 2009; Cangiano et al., 2009; Walsh & O’Shea, 2009). Walsh and O’Shea (2009:125) point out that being employed in a disadvantaged sector like old age care “intensifies the marginalization of an individual employee”. In respect to this, our study underscores the warning presented at the beginning of the paper, that research focusing solely on migrant care workers risks interpreting a general hardship associated with care work as unique to the specific category of migrant care workers. About 60 per cent of migrant care workers in our study experienced a lack of support from managers and this could be regarded as a proof of discrimination, were it not for the fact that similar numbers occurred among Swedish-born care workers.

As noted in several studies, some problems that affect migrant care workers stem from the informal and problematic conditions of care work (Doyle & Timonen, 2009; Cangiano et al., 2009; Walsh & O’Shea, 2009; Cangiano & Shutes, 2010). Given the different care regimes and patterns of migration between countries, it is difficult to generalize findings based on a Swedish dataset. From an international perspective the results of our study indicate a possibility of having a system where many migrant care workers become part of a well-established workforce. Sweden is a country where care work is embedded in a system of regulations (compare with Ungerson, 2004). At the same time the

threshold for participation in the labour market results in a high unemployment rate among immigrants as seen in OECD statistics (Ds 2011:17). Immigrants are discriminated in the sense that they struggle to get a foothold in the Swedish labour market (Hjerm, 2002; Ekberg & Roth, 2004; SOU 2004:73). Directing immigrants to (low-skilled, low-paid) care work has thus been framed as a solution to two problems, the other being an expected labour shortage (Lill, 2007). Simonazzi (2009) suggests that an increase in cheap, regular labour, possibly on a temporary basis, may occur in countries like Sweden where the formal care market predominates. It is possible to envision such a scenario as an effect of a recent legislative change that gives households a right to deduct tax for hired domestic work (primarily cleaning). An introduction of cash-for-care schemes has a similar potential of creating a more flexible labour market and thus increasing the participation of immigrants in care work. The obvious risk associated with this development is that working conditions become less favourable, similar to what we see in some other European countries (Ungerson, 2004; Simonazzi, 2009). Recent Swedish statistics show that an increasing number of foreign-born care workers come from countries outside the European Union (and in countries that only recently have become part of the EU), and this trend is particularly prevalent among care aides and personal assistants. More than 19 per cent of the members of these categories were born outside Sweden and 10 per cent were born outside the European Union (SCB, 2010). Higher numbers appear in the big cities of Stockholm, Gothenburg and Malmö. It has also been suggested that women from Poland and the Baltic states may have a growing role in providing personal/household services (Lyon & Glucksman, 2008). If immigrants end up in a type of work that is perceived as unattractive by the native-born population, this constitutes a form of discrimination.

In relation to the discussion on care models, it is of interest that the type of work where immigrants were particularly present was least associated with precariousness in our study. Personal assistance is an occupation with high employment turnover, and it could for this reason be expected that migrant care workers “end up” as personal assistants. This is indeed what our data show; 20 per cent of personal assistants were born outside Sweden. But being employed as a personal assistant was also associated with a lower rating on problem variables in comparison with being employed in elderly care and other forms of disability care. In another Nordcare publication Szebehely and Trydegård (2007) relates this difference to cutbacks in elderly care and increased resources being used to implement the personal assistance reform. The goal of personal assistance is to provide people with severe disabilities with opportunities “to live a life as anybody else” (Clevnert & Johansson, 2010:1). Although the shift of status of the service user may result in a lower degree of influence among personal assistants, as noted by Ungerson (2004), assistants are also empowered by a greater possibility of fulfilling the needs and requests of service users. The service users’ increased power to decide about work is embedded in a regulated employment and welfare system, a situation that is

drastically different from arrangements in southern Europe (cf. Ungerson, 2004; Simonazzi, 2009). Cangiano and Shutes (2010) argue that the basic problem to be addressed when investigating the situation of migrant care workers in the UK is *underfunding* of social care for older people. In accordance with our findings, this implies that the status of care users and the organization of care are crucial for understanding and improving conditions for care workers, regardless of descent.

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