Lightman, Naomi

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Naomi Lightman

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The "Migrant in the Market": Migration and Care Work Across Six Liberal Welfare Regimes

Naomi Lightman, PhD*

* Department of Sociology, University of Toronto, email: naomi.lightman@mail.utoronto.ca.
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Abstract

This article disaggregates high and low status care work, based on the degree of "social closure" in a given caring occupation, across six liberal welfare regimes: Australia, Canada, Ireland, Israel, the United Kingdom, and the United States. Bolstering the argument that there is a "migrant in the market" model of employment unique to liberal welfare regimes, the data demonstrate that foreign-born individuals are more likely to perform low status, precarious care work within each country than the native-born and that migrant workers experience an overall wage penalty in the labour force, as well as there being an additional penalty for those who perform service work in the realms of education and health.

Introduction

The majority of cross-national studies of care work provide comparisons across welfare regimes (e.g. Brennan et al., 2012; Lightman, 2016), examining how the relation of state, market and family influences earnings in the fields of health and education. Van Hooren (2012), for example, compares elderly care services across three welfare regimes: familialistic, social democratic, and liberal. She posits that within the latter, the market-oriented *liberal* welfare regime in England, there is a "migrant in the market" model of employment. This model disproportionately locates foreign-born care workers in the less regulated, more precarious, private sector, where working conditions are poorer and wages overall lower.

This paper builds on existing cross-national studies of paid care employment in two specific ways. First, by quantitatively examining the paid care economy in six liberal welfare regimes, I measure how and if care provisioning and outcomes are similar or different for individual countries *within* liberal welfare regimes, focusing specifically on the labour market outcomes of foreign-born individuals (the "migrants in the market"). Second, within each country of analysis, I examine variation within care work itself, disputing highly general definitions of care and complicating existing care work classification schemes. I disaggregate caring occupations with very low status (and salaries) and those with very high status (and often concomitant professional qualifications) and rely on the concept of "social closure" (Weber, 1956) to unpack any associated "care penalty" or "care bonus" (Weedon, 2002; Folbre, 2012), examining whether immigrant (also called "migrants" without distinction herein) are more likely than native-born populations to perform low status care.

Using the micro data files of the Luxembourg Income Study (LIS) I examine who is employed in what type of care work and compare the earnings of high and low status

(immigrant) care workers in Australia, Canada, Ireland, Israel, the United Kingdom (U.K.), and the United States (U.S.), in order to answer the following key questions:

1) Does distinguishing between care work occupations with higher and lower degrees of "social closure" allow for a more nuanced analysis of any concomitant "care penalty" (or "care bonus") across liberal welfare regimes?;
2) Are immigrants over or under represented in high and low status caring occupations within liberal welfare regimes (and to what degree)?; and
3) Are immigrant care workers financially penalized within liberal care regimes (and to what degree)?

Ultimately, the data demonstrate a significant care penalty within low status care work across all six liberal welfare regimes examined, and a significant care bonus for professionals (high status workers) in the fields of education and health in the majority of countries. Immigrants, in particular, are found to experience an additional pay penalty that ranges from 5-23% across the case study countries, even while controlling for a host of factors known to influence earnings. In addition, the data demonstrate that in the majority of countries examined immigrants are significantly less likely to be found in high status caring jobs and significantly more likely to be working in low status caring jobs. Altogether, the data reinforce the need to further specify what is meant by "care" (and consider who is providing which type of care and where) and suggest that resources and policy levers in each of the six countries of analysis ought to be directed towards immigrant women working in lower status caring occupations, as well as considering how market-oriented liberal care regimes disadvantage vulnerable workers and create precarious working conditions in the realm of care.

Migration and Care within Liberal Market Economies

Immigrant Stratification in Paid Care

Increasingly, paid care employment is conceptualized within a transnational labour market (or "global care chain"), where disadvantaged or poor immigrant women (who are also often racialized) provide care for pay in wealthier countries. Amidst a backdrop of rapidly aging populations and low domestic birth rates, female migrant workers provide a market-based solution to mounting "care deficits" in high and middle-income countries, as native-born women increasingly (re-)enter the workforce (Hochschild, 2012; Budig and Misra, 2010). Immigrant care workers often arrive with temporary work permits designed to discourage their broader integration or settlement (Peng, 2014; Haron, 2013) and may encounter widespread workplace discrimination and abuse, often while negotiating their own intergenerational family separations, in a context of growing public hostility about wage undercutting and displacement for the native-born (Anderson, 2010; Parreñas, 2013).

As a result of their limited employment options and, in some cases, vulnerability to deportation, immigrant women are often disproportionately located in lower status, or precarious, sectors of the paid care economy, working in jobs unattractive to native-born workers due to their low prestige and unpleasant working conditions (Duffy et al., 2013; Duffy, 2011). 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, and that this polarization is especially acute for those employed in the private sector.

Howes et al. (2012) document how recent shortages of nurses and teachers in the United States have been met by efforts to recruit from overseas, a strategy that makes it easier to restrict wage growth and to postpone investments in the state university systems that provide the bulk of training for these jobs. The United Kingdom, too, is increasingly dependent on nurses imported from Africa, while the Philippines, Indonesia and Vietnam export nurses as well as childcare workers to numerous wealthy countries, including Australia, Ireland, and Israel (Lim, 2015; Hugo, 2009; Cangiano and Walsh, 2014). In Canada, the federal Live-In Caregiver Program, instituted in 1992, has been criticized both for being exploitative to migrants and for being based on false premises tied to a rapid "pathway to citizenship" (Tungohan et al., 2015).

Thus, while the particular configurations of paid care employment vary depending on a country's occupational structure and policies on importing immigrant labour, across as well as within welfare regimes care work relies heavily on the premises of immigrant stratification. The following section identifies the unique characteristics of paid care provisioning within *liberal* welfare regimes, the central focus of this paper.

Liberal Welfare Regimes and the Commodification of Care

Broadly, welfare regime theory rests on the assumption that countries can be grouped into "clusters" based on the quality of social rights, the extent of social stratification, and the relation of state, market and family (Esping-Anderson, 1990; Mahon et al., 2012). Yet while such categorizations provide a convenient means to compare care economies, some scholars suggest that welfare regimes are outdated (and Eurocentric), and/or that differences within welfare regime categories are more important than the differences between them (e.g. Brennenstuhl et al., 2012; Jensen and Lolle, 2013).

The six countries analyzed in this paper, Australia, Canada, Ireland, Israel, the United Kingdom, and the United States, are all typically designated "liberal" welfare regimes (Ebbinghaus, 2012; Scruggs and Allan, 2008).[1] Countries categorized as liberal that are present in the Luxembourg Income Study (LIS) but were ultimately excluded from this analysis include New Zealand, Iceland, Switzerland and Japan.[2]

Under welfare regime theory, liberal states are thought to 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: 421). Liberal regimes are characterized by 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. Individuals within liberal welfare regimes are conceived of as discrete market actors and are encouraged to realise their potential and seek their welfare in the economic market, often through subsidies for private

[1] Historically, Israel was considered a social democratic welfare regime. However, due to a series of neoliberal government reforms beginning in the 1980s, Israel is now most commonly designated a liberal regime (see Gal 2004, Zambon et al. 2006).

[2] These countries were not included for a variety of reasons both conceptual and practical, including: because the countries have a low proportion of immigrants relative to the other case study countries, because they have universal benefits for child or elder care, because they do not have a variable measuring immigration status within the LIS dataset, or because they do not have industry and occupation variables in the LIS dataset that could be consistently measured to align with the other included liberal welfare regimes.

benefits. Basic security schemes are likely to be means-tested and social insurance benefits modest (Myles, 1998; Lightman and Lightman, in press).

Despite considerable variation at the state or provincial level, numerous similarities are identified across the liberal welfare regimes selected for analysis, supporting suggestions of an "ideal typical" regime type (Van Hooren, 2012). None of the six countries offer universal, state-supported childcare services and in each country, the cost of childcare usually exceeds any government subsidies, except for in the case of very poor families (Mahon et al., 2012). Like childcare, long-term eldercare is provided through a patchwork of arrangements in each country, with financing tied to socioeconomic status. In the majority of cases, national health insurance covers most medical and hospital-related costs for the elderly, as well as some (usually small) portion of the cost of medically related care either in privates home or institutions. However, the cost of non-medical care (e.g. assistance with activities of daily living) is covered through subsidies at the subnational level, private insurance, personal savings, and voluntary services (Boris and Klein, 2006; White, 2016). In addition, the quality of care accessed by those at higher and lower income levels is often widely divergent (Andersen and Curtis, 2015; Lightman and Lightman, in press).

Altogether, numerous similarities at the level of social care provisioning are identified within the six liberal welfare regimes analyzed herein. This paper seeks to examine if empirical evidence supports the hypothesis that there are similar outcomes amongst care workers, and specifically immigrant care workers, within the selected countries.

Operationalizing Care – Disaggregating High and Low Status Occupations

To date, there is no one uniformly accepted definition of care work. Typically, care work is defined as employment that involves face-to-face interactions with children, the elderly, or people with complex healthcare needs (England et al., 2002; Folbre and Wright, 2012). Oftentimes, care work is also identified as precarious – as insecure, offering workers limited protections and benefits, and minimal autonomy, recourse, or control (Standing, 2011; Vosko et al., 2003). Paid care employment is typically found to be undervalued and underpaid, in part due to its association with "women's work" (Folbre, 2012).

Some scholars rely on a very broad definition of care, conceptualized as entailing face-to-face human interactions between providers and recipients that develop or maintain the capabilities of the recipient (England et al., 2002). Such analyses combine individuals working in childcare, all levels of teaching (from preschool to university professors), all types of healthcare providers (from nurses aides to registered nurses to doctors), and include individuals in the "helping professions" (e.g. therapists, social workers, and clergy). Utilizing such a broad definition Budig and Misra (2012), find significant wage variation across welfare regimes. However, other authors, such as Williams (2012), suggests there has been considerable convergence in care provisioning accross wealthy nations, both in the commodification of care services and in the employment of migrant women.

The care work classification scheme utilized in this paper builds on the work of Weedon (2002), who applies a framework of "social closure" (Weber, 1956) to disaggregate higher and lower status caring occupations. This framework identifies whether specific caring occupations control access to the profession and collectively negotiate employment conditions and benefits (e.g. the degree of social closure this occupation achieves). A high degree of social closure is exemplified in the case of doctors and nurses, as well as many teachers. Barron and West (2013) expand Weedon's (2002) analysis within the United Kingdom, examining the "care bonus" and

"care penalty" in different caring occupations. The authors demonstrate a statistically significant wage penalty associated with working in certain caring occupations, specifically those requiring lower levels of educational qualification, such as nursing assistants and auxiliaries. However, for other occupations such as medicine and teaching, they find wages to be higher than in comparable non-caring occupations. The authors conclude that "although previous research in this area has suggested that the majority of the caring occupations face a wage penalty, the results reported here show that a more nuanced understanding of the status of care work is needed" (118).

Together, Weedon (2002) and Barron and West (2013) provide a strong rationale for disaggregating higher and lower status care work within the labour force, as well as examining who is performing which type of care. Lightman (2016) confirms the validity of this framework in an examination of the care economies in Canada, the United States, Japan, South Korea and Taiwan. Thus, the following section outlines the care work classification scheme and research design utilized in this paper, which seeks to examine both who performs what type of paid care employment and the wage variation in high and low status caring occupations within liberal welfare regimes, with a particular focus on the outcomes of "migrants in the market".

Research Design

To examine care work in-depth within liberal welfare regimes, this study uses the most recent micro data available from the Luxembourg Income Study (LIS) spanning the years 2010-2013. The LIS gathers cross-sectional data from household-based national surveys and harmonizes the data to ensure comparability, providing among the best cross-national data available for comparing incomes. For the analysis in this paper, the sample is limited to employed individuals aged 18-64 who are not enrolled as full-time students. The unweighted sample size for analysis ranges widely across countries, with Ireland and Israel with the smallest samples (at 3,219 and 10,416 individuals respectively), Australia and the U.K. with roughly 17-19,000 respondents each, Canada at approximately 26,000 individuals, and the U.S. with by far the largest sample size at 46,875 individuals.

In order to apply the ideas developed by Weedon (2002) within an international comparative context, my classification scheme distinguishes between high and low status care work (see Lightman, 2016). I focus on individuals working in the education, health and social work industries only (direct care), and I differentiate between "professionals" and "services workers", as a proxy for jobs with higher and lower status, and more or less social closure. Similar to Budig and Misra (2010) I identify care workers based on both occupation and industrial sector of the job: an individual must be identified as in both a caring occupation and a caring industry to be coded as having a care work job.

As the LIS contains harmonized data from a variety of country-specific datasets, different variables are available to indicate care industries and care occupations. Variables are selected to ensure congruency at the finest possible level. Examples of high status care workers include doctors, university professors, primary and secondary school teachers, nurses, and social workers. Examples of low status care workers include childcare workers and teachers' aides, healthcare assistants, visiting homemakers and housekeepers. Table 1 details the care work classification scheme used.

[Insert Table 1 here]

Following Weeden (2002), I hypothesize that across the case study countries (Australia, Canada, Ireland, Israel, the U.K. and the U.S.) caring occupations that have achieved lower levels of social closure (low status care workers) will be more likely to comprise disproportionate numbers of women, immigrants, and individuals in non-standard (precarious) employment (Vosko et al., 2003), and that this will result in overall lower earnings than non-caring professions. Yet for those individuals in high status care work, I expect to see a care bonus across the liberal welfare regimes, in part due to the higher level of social closure within these occupations, and to see an under-representation of immigrant workers. I also anticipate that immigrant workers will receive a pay penalty overall (controlling for work in care) and that there will be variation across the countries of analysis, tied to the degree to which each country's labour market is regulated, and thus, to some degree, disputing suggestions of convergence within liberal welfare regimes.

Variables of Interest

My descriptive and multivariate analyses examine both who engages in care work and capture wage variations in high and low status care employment, specifically focusing on immigrants. In the logistic regressions the dependent variables are a dichotomous measure of high or low status care (coded as 1 for employment in a high/low status caring occupation and 0 for otherwise). In the multivariate regressions, the dependent variable is the natural log of annual earnings (including wages and self-employment income) with extreme earnings recoded to the 1 percent and 90 percent values of within-country earnings distributions. Logged earnings have the benefit of normalizing the earnings distribution as well as allowing the transformed regression coefficients to be interpreted as approximate percentage changes in earnings for a one-unit change in the independent variable (Budig and Misra, 2010).[3]

The main independent variables compare low status and high status care workers to individuals not in a caring profession, as well as comparing immigrants (defined here as people who born outside of the country) to individuals born in the country.[4] In order to specify any particular care penalty or care bonus, as well as capture any added disadvantage experienced by immigrants, as many conceptually relevant control variables as are available across the datasets are also 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. 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). Low education is the reference category (Budig and Misra, 2010).

To capture the effects of job characteristics on earnings, five variables are included in the

[3] The transformation of coefficients into percentages was done using the equation suggested by Kennedy (1981) of 100*(exp(b)-1).

[4] In all countries the immigration variable does not account for variation in residency status or entry class. Individuals in the country without formal legal status are either excluded or under-sampled. In addition, the immigration variable in the Canadian dataset only includes individuals who live in an urban area of 500,000 persons or more. These are noted as potential drawbacks to the data analysis.

final models, where available: a control for part time work status (compared to full-time), one for employment in the public/non-profit sector (compared to in the private sector), one for being self-employed (as opposed to being an employee), one for being a multiple job holder (versus having a single job), and one for having non-permanent employment (compared to permanent employment). Each of the former categories is coded as 1.

By including the aforementioned variables, the goal is both to ensure that the relationship between low or high earnings and care work, as well as between low earnings and immigrant status, is not attributable to these factors, and to explore if and how each of these variables is influential and if the effect varies across liberal welfare regimes. Notably, the LIS data does not include consistent measures of respondents' race/ethnicity across each dataset, which would further enhance this analysis. In each case the reference category is considered the more/most privileged position or the category with the largest number of responses.

Results

Descriptive Analyses

Descriptive analyses allow for an examination of the state of the labour force in each country (Table 2) as well as a profile of the high and low status care workforce (Tables 3 and 4) to examine trends within liberal welfare regimes. In each country, females make up just under half of the workforce (ranging from 45.1% in Australia to 47.4% in Ireland). However, there is considerable variation in terms of percentage of immigrants in the labour force within each country. The U.K. has the lowest percentage of immigrants (at 15.9%), followed by the U.S. and Ireland (at 19.4% and 21.5% respectively), with the foreign-born in Australia, Israel and Canada comprising approximately 30% of their workforce.

In terms of overall labour force characteristics, the data demonstrate considerable variation in terms of the composition of workers and the reliance on those considered "precarious" across liberal welfare regimes. However, each country abides by the general principles of a market-oriented labour market, with relatively minimal reliance on public sector workers. Specifically, the data demonstrate that the U.S. has the lowest percentage of public sector workers (at 19.4%) and Ireland has the highest (at 26.8%) for countries where the information is available. However, the data show the opposite trend in terms of part-time workers, with the U.S. having amongst the lowest percentages (at 13.8%, only slightly higher than Canada and Israel at 12.2% and 13.2% respectively), and Ireland with the highest percentage (at 29.6%). The percentage of self-employed individuals is clustered between 8-11% for all countries besides the United Kingdom (at 4.4%), while Canada has by far the lowest percentage of nonpermanent workers where data is available (at 0.9%). Multiple job holdings are most frequent in Australia (at 7.4% of the workforce) and least common in Israel (where they comprise only 1.3% of the workforce).

[Insert Table 2 here]

Narrowing the focus to high status care workers, Table 3 descriptively examines professionals in the fields of health and education. Here the data demonstrate that in all cases the mean earnings of high status care workers are higher than for the total population. The advantage is smallest in Israel, where high status care workers make, on average, about 16% higher earnings than the overall population, and largest in Ireland (where high status care workers have

a 44% advantage, on average). In the rest of the countries the advantage ranges between 21% in Australia and 29% in the U.K. Thus, in each case, high status care workers are, on average, relatively well off within liberal welfare regimes.

From Table 3 we also see that the proportion of the population working in high status care work ranges from 9.6% in the U.K. to 5.4% in Israel. Females are overrepresented in these occupations, ranging from the country with the greatest gender parity, at 66% female (in Israel), to the U.K. where women comprise 73.7% of the high status care workforce. Across the six countries the data demonstrate that high status care work predominates in the public sector, has lower levels of self-employment than the total workforce, and has higher levels of non-permanent employment and multiple job holdings than the workforce on average. In addition, these occupations tend towards a higher proportion of workers in part-time employment than the total workforce in all cases besides the U.S.

[Insert Table 3 here]

Table 4 shifts the focus to low status care workers. Here the data demonstrate that in all countries examined low status care work comprises a smaller percentage of the workforce than high status care work, ranging from 6.8% in the U.K. to only 2.3% in Canada. As anticipated, in all countries there is a major financial disadvantage to working in low status care. Low status care workers fare worst in Israel and the U.S. where they make on average only 42% and 46% as much in earnings as the total workforce. Yet even in the best case scenarios, in Australia and the U.K., low status care workers still only make, respectively, 58% and 55% as much in earnings as the total workforce on average. In all countries the percentage of females is higher in low status care than in high status care. Notably, Israel has the highest proportion of women in low status care work (at 93.2% female), supporting Weedon's (2002) prior finding that, separate from the degree of social closure, the extent of feminization in the workforce negatively impacts the average earnings in an occupation.

Immigrants are also overrepresented in low status care in five out of the six liberal welfare regimes, most prominently in Israel (where they are 46.6% overrepresented as compared to the total workforce), followed by Canada (18% overrepresented), Ireland (17.7%), the U.S. (16%), and Australia (just 1.1%). Interestingly, immigrants are underrepresented in low status care in the U.K. (by 19.5%). In terms of job characteristics, low status care workers are less likely than high status care workers to be employed in the public/non-profit sector, where worker conditions are suggested by Van Hooren's (2012) model to be better. In all the countries examined, low status care workers are also substantially more likely to have part-time employment or be multiple job holders than high status care workers, suggesting conditions of precarious work.

[Insert Table 4 here]

Overall, the descriptive data support the hypothesis that there are substantial differences between the high and low status care workforce in terms of both demographics and job characteristics across liberal welfare regimes. Without controlling for any other factors, in all countries there is a care bonus for high status care work and a substantial care penalty for low status care work. In addition, the low status care workforce is more feminized, overall more likely to be comprised of immigrants, and more likely to be situated in the private sector than the

high status care workforce. Thus, data demonstrate an overall trend within liberal welfare regimes supportive of a "migrant in the market" framework.

Multivariate analysis

The odds of performing high and low status care work

Tables 5 and 6 allow for examination of whether immigrants are more or less likely to perform high and low status care work as compared to the native-born populations across the six liberal welfare regimes, controlling for family structure and demographic characteristics, as well as human capital (level of education).[5] Results are presented in the form of odds ratios, and are to be interpreted as the change in odds of the dependent variable, given a one unit change in the independent variable. Odds ratios are obtained through exponentiation the coefficients and can take on values from 0 to ∞, where a value less than one is interpreted as a negative effect, and a value above one is a positive effect.

Table 5 demonstrates that in four out of the six countries examined, immigrants are significantly less likely to engage in high status care work as opposed to other occupations. Immigrants are least likely to be high status care workers in the U.S. (0.48, or 52% lower odds than the American-born), followed by Canada (0.56, or 44% lower odds than the Canadian-born), Australia (0.76, or 24% lower odds), and Israel (0.79, or 21% lower odds). In Ireland and the U.K. there is no significant difference, suggesting that immigrants within these countries are equally likely as the native-born to work in high status care. Table 5 also demonstrates that women have at least twice as high odds of being in high status care work as men across each of the liberal welfare regimes, and that individuals in high status care are most likely to have a high level of education, controlling for the other factors.

[Insert Table 5 here]

Table 6 demonstrates an opposite trend in terms of likelihood of immigrants to perform low status care work across the welfare regimes, as anticipated by the literature (e.g. Folbre, 2012). Here the data demonstrate that in four out of the six countries examined immigrants are significantly more likely to engage in low status care than the native-born. Immigrants are relatively most likely to be low status care workers in the U.S (1.60, or 60% higher odds than American-born), followed by the U.K. (1.56, or 56% greater odds than the U.K.-born). The magnitude of the effect is smaller but still significant in Israel (1.18 or 18% higher odds for immigrants than the Israeli-born) and Canada (1.13 or 13% higher odds than the Canadian-born). In Ireland and Australia there is no significant difference, suggesting that immigrants within these countries are equally likely as the native-born to work in low status care. Table 6 also demonstrates that in all cases women are considerably more likely to be in low status care than men (most notably 21 times more likely in the U.S.) and that they have higher odds of having a low or medium level of education (as compared to a high level of education), controlling for the other factors.

[5] To give equal weight to each country in the models, population weights normalizing to 10,000 by country are applied to the multivariate analyses, to make the highly divergent population sizes in the samples more comparable (Kangas 2016).

[Insert Table 6 here]

Altogether, the logistic regressions demonstrate a trend of higher odds of immigrant employment in low status care and lower odds of employment in high status care than the native-born populations across the majority of liberal welfare regimes, controlling for gender, demographic factors, and human capital. In order to answer the final research questions, examining the wage bonuses and penalties for high and low status care, as well as for immigrants overall, the final table present findings from Ordinary Least Squares regressions.

Care bonuses and care penalties

Table 7 presents the log earnings for high and low status care work, as well as for immigrants, across each liberal welfare regime examined, measured as a function of gender, age, marital/cohabitation status, the presence of young children in the household, education level, and job characteristics, including public/non-profit sector employment, part-time status, self-employment, non-permanent employment and being a multiple job holder, where the data is available.

For high status care work, with the application of the above controls, there remains a significant care bonus in four of the six countries examined. This care bonus ranges from 15% in Australia, to 18% in the U.K., to 24% in Israel, to 26% in Ireland. There is no significant care bonus in the two countries included in North America, Canada and the U.S., suggesting that in these countries the higher than average earnings of professional in health and education are at least partially attributable to the higher levels of education of these workers, as well as the job characteristics of these occupations (e.g. rates of public sector and permanent employment).

For low status care work the data demonstrate a powerful trend across all the liberal welfare regimes included. In each country there is a significant care penalty for low status care work. This care penalty is smallest in Australia (at -13%), followed by the U.S. and Ireland (at -22% and -29% respectively), and is above 30% in the U.K., Israel and Canada (at -31%, -38% and -48% respectively). Thus, even after controlling for gender, human capital and job characteristics, low status care workers are significantly disadvantaged in their earnings across all six liberal welfare regimes, bolstering prior findings of a low social value accorded to low status care (Lightman, 2016).

Finally, as sample sizes did not allow for an examination of the specific wage penalty experienced by immigrants within high and low status care work, Table 7 presented the overall wage penalty for immigrants in the labour force, which takes on added importance given the prior finding that immigrants are more likely to be in low status care work in the majority of countries. Here the data demonstrate that across all the liberal welfare regimes examined immigrants experience a significant wage penalty, which ranges from 5% in Australia and the U.S., to 8% in the U.K., to 18% in Canada, to 21% in Ireland, and is a full 23% earnings penalty in Israel. Thus, the data demonstrate that the countries that have a larger wage penalty in low status care work also tend to have a larger wage penalty for immigrants, suggesting that the market mechanisms that disadvantage certain caring occupations may also lead to the marginalization of foreign-born populations.

[Insert Table 7 here]

Conclusions

This paper moves beyond highly aggregated measures of care work, which often combine high and low status occupations. Rather than assuming that all care work is highly feminized, poorly paid, and precarious, the classifications scheme developed and applied with the LIS dataset empirically measures differences between and within care employment in six liberal welfare regimes: Australia, Canada, Ireland, Israel, the United Kingdom, and the United States. In addition, I examine whether immigrants are more likely to perform high or low status care and if they incur an additional wage penalty for being foreign-born.

The descriptive data support the hypothesis that there are substantial differences between the high and low status care workforce across liberal welfare regimes, distinguished here in terms of the degree of "social closure" (Weber 1956). Without controlling for other factors, in all countries there is a major care bonus for high status care work and a substantial care penalty for low status care work. As well, the low status care workforce is more feminized, more likely to be comprised of immigrants, and more likely to be situated in the private sector, than the high status care workforce, supporting previous research on "migrants in the market" (Van Hooren, 2012).

The subsequent multivariate analyses allow for examination of who is performing high and low status care work as well as examining earnings with the addition of conceptually relevant control variables. The logistic regressions demonstrate that in the majority of countries examined immigrants are significantly less likely than the native-born to be working in high status caring jobs and significantly more likely to be working in low status caring jobs. Building on this finding, the OLS regressions demonstrate that not only is there a significant care bonus for high status care workers in the majority of countries and a significant and substantial care penalty within low status care work across all six liberal welfare regimes examined, but immigrants experience an additional pay penalty that ranges from 5-23% across the case study countries.

These findings are meaningful in the current policy context. Within liberal welfare regimes there has been a consistent trend over time of converting the objectives of health and education from the delivery of a public good that is beneficial to the whole of society, to the sale of a market commodity tailored to specific (economically advantaged) groups (Lightman and Lightman, in press). This is a process that Ilcan (2009) has termed "privatizing responsibility" in government. In addition, scholars such as Oesch (2014) note that liberal welfare regimes lead to occupational polarization within paid care work; by allowing earnings in interpersonal services to adjust to lower productivity growth, there has been an increase in service jobs paid at poverty-level wages in elder and child care. Thus, growth in the caring industry is disproportionately located in low status, more precarious occupations. In this context of government austerity and earnings polarization across liberal welfare regime, the data from this paper overall suggest that "migrants in the market" are not faring well: they are disproportionately located within low status, more precarious, and lower paid forms of care work, and experience an additional pay penalty for being foreign-born net of their personal characteristics and human capital.

Table 1: Details of Care Work Classification Scheme, Luxembourg Income Study, 2010-2013

Country, Sample Size, Dataset	Care Industry Variables	Care Occupation Variables
Australia (N=16,770) *2010 Household Expenditure Survey (HES) and Survey of Income and Housing (HIS)* Canada (N = 26,310) *2010 Survey of Labour and Income Dynamics* Ireland (N= 3,219) *2010 Survey of Income and Living Conditions* Israel (N = 10,416) *2012 Household Expenditure Survey* United Kingdom (N = 18,919) *2013 Family Resources Survey* United States (N= 46,875) *2013 Current Population Survey – ASEC (Annual Social and Economic Supplement)*	Education *and* Health and Social Work	*High Status Care* Professionals *Low Status Care* Community, Service and Sales Workers

Note: Population is limited to individuals aged 18-64, who are employed and are not enrolled as full-time students. Classification scheme is adapted from Lightman (2016.)

Table 2: Overview of Workforce (%)

	Australia, 2010	Canada, 2010	Ireland, 2010	Israel, 2012	United Kingdom, 2013	United States, 2013
Female	45.1	47.2	47.4	46.6	46.9	46.7
Immigrant	28.1	30.5	21.5	29.8	15.9	19.4
Labour Force Characteristics						
Public/non-profit sector	N/A	22.1	26.8	N/A	25.4	19.4
Part-time employment	26.6	12.2	29.6	13.2	20.6	13.8
Self-employed	8.5	8.2	10.3	11.0	4.4	8.4
Non-permanent employment	N/A	0.9	6.2	N/A	5.9	N/A
Multiple job holder	7.4	N/A	N/A	1.3	3.8	4.7

Note: 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: High Status Care Work – Professionals in Health and Education (%)

	Australia, 2010	Canada, 2010	Ireland, 2010	Israel, 2012	United Kingdom, 2013	United States, 2013
Percent of Total Workforce	9.5	6.9	8.2	5.4	9.6	7.7
Female	67.7	71.3	73.0	66.0	73.7	70.2
Immigrant	29.7	20.8	25.1	23.8	19.1	13.4
Labour Force Characteristics						
Public/non-profit sector	N/A	81.9	75.9	N/A	83.9	68.5
Part-time employment	30.6	16.3	40.2	25.9	23.5	12.5
Self-employed	4.2	4.0	3.4	10.8	2.7	4.1
Non-permanent employment	N/A	2.1	9.2	N/A	7.3	N/A
Multiple job holder	13.3	N/A	N/A	2.6	6.2	6.9
Ratio: High Status Care Mean Earnings/Total Mean Earnings	1.21	1.25	1.44	1.16	1.29	1.23

Note: 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: Low Status Care Work – Service/Care Workers in Health and Education (%)

	Australia, 2010	Canada, 2010	Ireland, 2010	Israel, 2012	United Kingdom, 2013	United States, 2013
Percent of Total Workforce	4.7	2.3	4.2	4.8	6.8	3.1
Female	85.4	76.3	90.8	93.2	85.7	86.7
Immigrant	28.4	36.0	25.3	43.7	12.6	22.5
Job Characteristics						
Public/non-profit sector	N/A	72.5	47.8	N/A	50.7	27.7
Part-time employment	56.6	31.7	61.2	32.2	37.7	29.2
Self-employed	7.0	1.6	0.1	5.4	1.2	12.3
Non-permanent employment	N/A	1.2	12.2	N/A	6.6	N/A
Multiple job holder	12.9	N/A	N/A	2.3	5.6	6.3
Ratio: Low Status Care Mean Earnings/Total Mean Earnings	0.58	0.54	0.50	0.42	0.55	0.46

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

Table 5: Binary Logistic Regression: Odds of Performing HIGH STATUS Paid Care Work by Country

	Australia, 2010		Canada, 2010		Ireland, 2010		Israel, 2012		United Kingdom, 2013		United States, 2013	
Population Groups	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**
Male	rg		rg		rg		rg		rg		rg	
Female	2.53	***	2.58	***	3.59	***	2.56	***	3.74	***	2.05	***
Native-born	rg		rg		rg		rg		rg		rg	
Immigrant	0.76	*	0.56	**	1.05	ns	0.79	*	1.01	ns	0.48	***
Age	1.02	***	1.01	ns	1.02	***	1.00	ns	1.06	***	1.03	**
Single/separated/divorced/widowed	rg		rg		rg		rg		rg		rg	
Married/common-law	1.04	ns	1.16	ns	1.03	ns	1.18	ns	0.99	ns	1.05	ns
Living with own child, aged 0-5 yrs	1.15	ns	1.10	ns	1.09	ns	1.29	ns	1.35	ns	1.12	ns
Other	rg		rg		rg		rg		rg		rg	
Low education	0.02	***	0.06	**	0.01	***	0.02	***	0.01	na	0.06	***
Medium education	0.06	***	0.14	***	0.04	***	0.09	***	0.05	***	0.04	***
High education	rg		rg		rg		rg		rg		rg	
Constant	0.07	***	0.05	***	0.05	***	0.09	***	0.01	***	0.03	***
-2 Log Likelihood	2144		1084		2090		1510		1324		1285	
Cox & Snell R Square	0.14		0.05		0.15		0.09		0.13		0.07	
Nagelkerke R Square	0.31		0.12		0.32		0.21		0.30		0.21	
N	16,722		7,412		3,071		10,379		18,792		46,875	

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

Table 6: Binary Logistic Regression: Odds of Performing LOW STATUS Paid Care Work by Country

	Australia, 2010		Canada, 2010		Ireland, 2010		Israel, 2012		United Kingdom, 2013		United States, 2013	
Population Groups	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**	**Exp(b)**	**Sig.**
Male	rg		rg		rg		rg		rg		rg	
Female	8.44	***	2.94	***	8.04	***	8.90	***	13.26	***	21.31	***
Native-born	rg		rg		rg		rg		Rg		rg	
Immigrant	1.08	ns	1.13	*	0.91	ns	1.18	*	1.56	*	1.60	***
Age	1.02	**	1.04	*	1.01	*	1.01	ns	1.00	ns	1.03	**
Single/separated/divorced/widowed	rg		rg		rg		rg		rg		rg	
Married/common-law	0.78	ns	0.81	ns	0.75	*	0.78	ns	0.91	ns	1.08	ns
Living with own child, aged 0-5 yrs	1.35	ns	1.06	ns	1.10	ns	1.16	ns	0.72	*	1.17	ns
Other	rg		rg		rg		rg		rg		rg	
Low education	1.00	Ns	2.47	*	1.77	*	3.88	***	4.16	***	4.15	***
Medium education	2.14	***	1.80	ns	2.14	***	3.19	***	2.52	***	2.73	***
High education	rg		rg		rg		rg		rg		rg	
Constant	0.01	***	0.01	***	0.00	***	0.01	***	0.01	***	0.01	***
-2 Log Likelihood	1520		422		1951		820		912		1155	
Cox & Snell R Square	0.04		0.01		0.06		0.03		0.05		0.07	
Nagelkerke R Square	0.13		0.06		0.14		0.13		0.17		0.21	
N	16,722		7,142		3,071		10,379		18,792		46,875	

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

Table 7: Percentage Point Differences in Annual Earnings for High and Low Status Care Workers (Relative to Non-Care Workers) and for Immigrants (relative to Native-Born) by Country[(a)]

	High Status Care Work	Low Status Care Work	Immigrants
Liberal Welfare States			
Australia[1]	**15**	**-13**	**-5**
Canada[2]	12	**-48**	**-18**
United Kingdom	**18**	**-31**	**-8**
United States[3]	01	**-22**	**-5**
Ireland[4]	**26**	**-29**	**-21**
Israel[5]	**24**	**-38**	**-23**

[a)] Results control for gender, family structure and demographic characteristics (age, marital status/cohabitation, and the presence of young children in the household), human capital (education level); and job characteristics (part-time employment, public sector employment, self-employment, being a multiple job holder and non-permanent employment).
[1] The Australia dataset does not include variables for public sector or non-permanent employment.
[2] The Canadian dataset does not include a variable for being a multiple job holder.
[3] The United States dataset does not include a variable for non-permanent employment.
[4] The Ireland States dataset does not include a variable for non-permanent employment.
[5] The Israel dataset does not include variables for public sector, self-employment or non-permanent employment.
Significant effects (p < .05) are bolded.
Note: Population is limited to employed individuals aged 18-64, who are not enrolled as students and who have earnings greater than $0.

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