Chapter 9. Low-skilled migration: Immigrant workers in European domestic care*

Over the last 15 years, since the entry into force of the Amsterdam Treaty, migration policies in the European Union have principally focused on security-related issues of migration, such as border management, visa policy and readmission agreements. The European Commission's directives have concentrated on the entry and residence of specific groups: students, researchers and high-skilled migrants.[1] In addition, EU member states have followed a selective and sectoral approach in the admission of immigrants, and a growing number of countries have been adopting points-based systems. In several EU member countries, however, the unprecedented increase of immigrant labour happened rather in low-skilled occupations. The domestic care sector has attracted a particularly high share of migrants and in some countries massive immigration of low-skilled[2] female workers has continued since the onset of the global financial crisis.[3]

These trends[4] raise a number of policy-related questions in the areas of migration, care and employment. Why have certain countries proved to be particularly attractive for immigrant care workers? How are the different European welfare and care regimes, and state and market policy mixes, shaping the inflow of low-skilled migrants into the care sector? What are the impacts of this migration of predominantly low-skilled women on care systems, female employment opportunities and gender equality in the receiving and sending countries? How is the position of the new EU member states that have been among the main sending countries within the European transnational care chain changing? What are the working conditions in the domestic care sector and what kind of policies could ensure that the sector provides decent employment opportunities for both migrant and non-migrant workers along the lines of the socio-economic transition (SET)?[5]

Welfare regimes, transnational care chains, national state/market care policy mixes and family policies are shaping low-skilled migration into the care sector

9.1 Migrants are increasingly overrepresented in domestic care employment

Domestic care has in recent times been one of the most dynamic sectors of employment in Europe. Estimations on the basis of EU Labour Force Survey data indicate that the number of domestic care workers increased by about 40% in the EU-15 member states[6] between 2000 and 2010[7], and the majority of domestic care workers in the EU are migrant women.[8] Moreover, of the three major sectors where migrants are strongly overrepresented, only "private households with employed persons" have expanded in terms of employment since the onset of the recent crisis (the two other industries where migrants are significantly overrepresented – hotels and restaurants, and especially construction – suffered significant employment losses after 2007). Altogether, in European OECD member countries, 424,000 new jobs were taken by foreign-born workers in care-work-related sectors between 2008 and 2012: employment of immigrants increased by 20.2% in "activities of households as employers of domestic personnel" and by 44.5% in residential care activities (see Figure 1).[9]

Domestic care is a fast expanding sector in employment terms and a key sector for migrant employment

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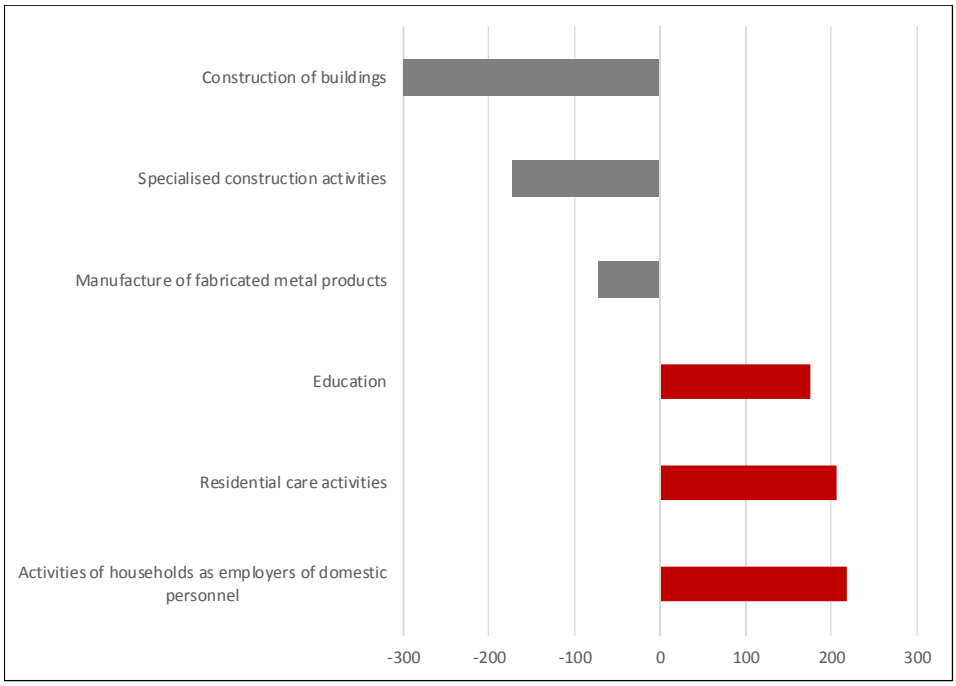
Figure 1. Three industries with largest positive and negative changes in foreign-born employment in European OECD countries, 2008-2012 (thousands of people)



Source: OECD (2013).

Concerning future prospects, the NEMESIS model[10] forecasts a significant increase in care demand by 2025 in Europe: by 15-22% in the tough scenario and 28-39% in friendly scenario. The care workforce supply will not be able to meet this growing care demand without significant migrant labour inflows, as the supply of domestic care labourers is expected to increase by less than 10% in the tough scenario and by 12-28% in the friendly scenario.[11] Unless major policy changes are made in the field, policy-makers will have to count on a further substantial increase of migrant care workers over the next decades.

9.2 Migrant domestic workers meet European care demand through transnational care chains

The role of migrant domestic workers has long been recognised in meeting European needs for care.[12] Yet, due to a lack of reliable comparative data and a large component of informal employment of migrant care workers, analysts have been cautious about including the assessment of migrant flows when discussing care policies. From a policy perspective, the key mechanisms can be interpreted at the intersections of migration, employment, and national welfare and care regimes.[13] The approach of transnational care chains explores the connection between care work, migration, and social and gender inequalities in a global perspective.[14] Care is commodified and mainly female care workers are imported from less developed to more developed parts of the world.

Transnational care chains in Europe involve the migration of Eastern European women to provide care in Western European homes

Care chains imply that paid forms of care (be it domestic work or care for children, the elderly or the sick) have become an important source of employment for women in many developing and Eastern European countries. Joining the labour force, however, requires a substitute for migrating women's role in their own families. Accordingly, intra-EU migration within European care chains encompasses the exodus of Eastern European women from their

homes to provide care in the homes of others, and also the impacts of this female migration outflow on care systems and families in Central and Eastern Europe.

The role of migrants in care provision is fairly uneven across Europe. Why are some countries particularly attractive for immigrant domestic care workers? Several factors matter in this respect, foremost of which are the specific features of national welfare and care regimes: institutional provision of care (e.g. kindergartens, social workers, and retirement homes), policies on work-life balance, and monetary subsidies for care provision (e.g. welfare payments or tax relief). Moreover, by imposing certain migration regimes or occupational quotas for domestic workers, states can create indirect incentives for a rising market of private care workers of immigrant origin. Concerning the inclusion of immigrant populations, at least two dimensions matter: legal, formal access to citizenship, and the multicultural policy framework shaping the socio-political inclusion of immigrant populations.[15]

It should be noted that migration policy regime typologies and assessments usually have a Western receiving country bias. The attention to new currents of labour migration from Central and Eastern Europe (CEE) to Nordic, Western and Southern European countries overshadows migration chains in which CEE countries function both as sending and receiving entities of low-skilled care workers and are thus themselves in the process of building migration policy regimes. In addition, in the predominantly sending Eastern European countries, the massive outflow of female care workers aggravates welfare, care and family policy tensions, particularly because of the low level of fertility and the general withdrawal of publicly provided welfare and care services over the last two decades.

9.3 The demand for migrant care workers is typically a demand for jobs with substandard conditions

Two major factors feed the expansion of the care sector in EU countries, and both are related to population ageing in European societies. Low fertility rates have implied an increasing policy focus on child care services, while the trend of population ageing itself has generated growing demand for elderly care provisions. Moreover, there is an additional factor of a fiscal nature supporting the demand for domestic care workers: the spread of cash-for-care schemes as part of the welfare reform agenda enhances the commodification of care through the direct provision of financial resources to users, and opens up opportunities for the incorporation of paid domestic and care work.[16]

Population ageing and the spread of cash-for-care schemes feed the demand for domestic care workers...

But why are native populations strongly underrepresented among domestic care workers? Indeed, the demand for migrant care workers is a specific form of demand: typically, a need for migrant women who are willing to take jobs with substandard wages and employment conditions that are unacceptable to the native workers.[17] The wage levels of immigrant care workers indicate that they are overrepresented at the lower end of the pay scale of this sector. Paradoxically, stronger immigration control indirectly supports the ability of employers to 'underpay' migrant care workers. Because pull factors of migration dominate in Western European care labour markets, stricter border control cannot effectively discourage the arrival of immigrants.[18] And without permission to work, immigrants with irregular status become particularly vulnerable to abuse of working conditions.[19] Employers thus often rely on immigrants who are ready to provide care services in a more flexible, informal and insecure working environment.[20] These substandard

... but with substandard wages and employment conditions

working conditions, while attracting a particularly vulnerable segment of immigrants, indirectly close the domestic care sector employment opportunities for native low-skilled workers.

9.4 Liberal and Southern welfare regimes are particularly attractive for immigrant care workers

The presence of migrant domestic care workers is fairly uneven across European countries, and Italy and Spain are the two major target countries for CEE migrants in this field. But why are the Mediterranean countries more attractive for low-skilled immigrant care workers than their more developed Northwestern European counterparts? Most explanations of the care-migration nexus depart from Esping-Andersen's typology of welfare regimes,[21] which distinguished three major types of welfare in Western Europe: the liberal, the conservative and the social-democratic welfare regimes. Following later empirical research, two additions to the original typology of Esping-Andersen seem relevant in order to embrace a larger European perspective: the Mediterranean or Southern European regime type,[22] and the post-socialist or Central and Eastern European[23] regime type. Table 1 summarises the care-specific characteristics of European welfare regimes[24] using the main features of care systems: the level of financial generosity, the dominant institution of care and the role of formal versus informal types of care provision. It also presents the migration pattern of care workers in the particular welfare regimes.

Table 1. Main features of care in European welfare regimes[25] and migration impacts

Welfare regime	Financial generosity of care	Dominant institution of care	Formal vs. informal dimension of care	Migration position in care chains
Social-democratic (Nordic)	High	State	Formal	Receiving, moderately intensive
Conservative (Bismarckian, Christian-democratic)	High	State /mixed	Partly informal	Receiving, moderately intensive
Liberal (Anglo-Saxon)	Medium/ low	Market	Partly informal	Receiving
Southern (Mediterranean)	Low/ medium	Family	Mainly informal	Receiving, intensive
Post-socialist (Central and Eastern European new member states)	Low / medium	Family / state	Mainly informal	Sending within the EU, but receiving in global care chains

Source: Own elaboration based on typologies of Esping-Andersen (1990), Sapir (2006), Williams and Gavanas (2008), Kraus *et al*. (2010), Hemerijck (2013), and Korpi *et al*. (2013).

Limited public provision of care and a stronger role of informality attracts many immigrants to liberal and especially Southern welfare regimes

The lower the level of generosity in public financing of care, the higher the importance of non-state care-providing institutions (i.e. the market and family), and the stronger role of informality in care provisions in particular may well predict the immigration potential in different welfare regimes. Thus in the Nordic countries, where good quality care is publicly provided, the demand for immigrant care workers is rather limited. The Western European Bismarckian countries follow a similar pattern, though the importance of informal relations and the stronger role of family in care results in a less straightforward picture.[26] In the liberal regime, however, less generous financing of care and a stronger role of the market logically implies a higher level of demand for less expensive migrant care services. And in the Mediterranean countries – where public provision of welfare services is more limited, care is traditionally provided by family members, and informality plays a

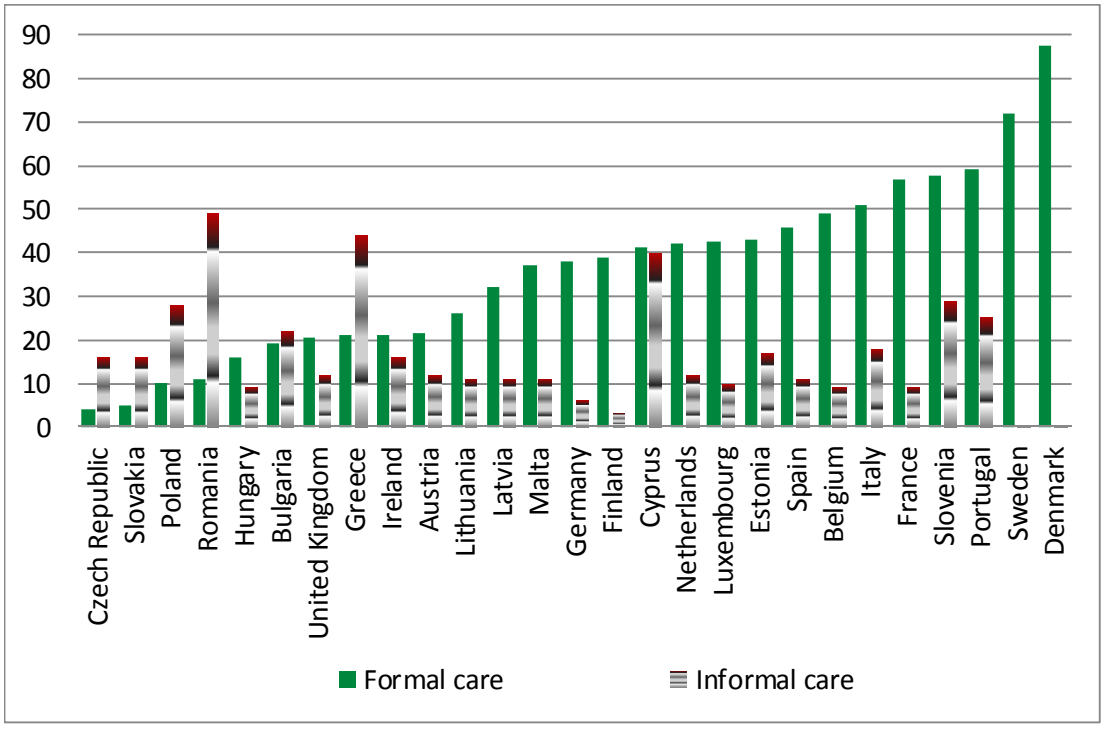
dominant role in socio-economic transactions – the specific demand for immigrant care is striking.[27]

The group of post-socialist countries is more heterogeneous than the other four welfare regime types. Though some of the CEE EU member states follow rather Bismarckian conservative patterns, concerning the main features of care most show a marked similarity with the Mediterranean countries of the EU. This implies that in the future, assuming that wage differentials between Western and Eastern European countries gradually fall, we can expect that typical CEE countries will provide less migrant care workers for Western Europe, and at the same time will also attract an increasing number of immigrants for domestic care tasks. Thus, post-socialist states will likely become important destinations within the global care chain, importing care workers from the Global South and especially from the Eastern Partnership (EaP) countries.[28] This process is indeed ongoing: a share of the migration of Ukrainian domestic care workers has recently been redirected to Poland.[29]

Familialist care policy patterns support informal care use in several Mediterranean and post-socialist countries

This surprising similarity in care policy features between Mediterranean and Central and Eastern European countries mainly derives from the re-familialisation policy tendencies in the latter group of countries: over the last 25 years, the post-socialist countries have followed – either explicitly or implicitly – a familialist care policy pattern.[30] As a result, while formal early childcare use (below the age of three) was high in CEE countries compared to Western Europe during the state socialist period, today formal care use in early childhood is lowest in the post-socialist countries (see Figure 2). The underdevelopment of formal institutional care implies that if parental care is not available (or not desirable) to households, then informal care becomes the dominant option. This provides an indirect incentive for recruitment of migrant domestic care workers in post-socialist member states. At the same time, the traditionally familialist Mediterranean childcare policy shifted in the opposite direction, and public care provision in the early childhood period significantly improved in Southern Europe.

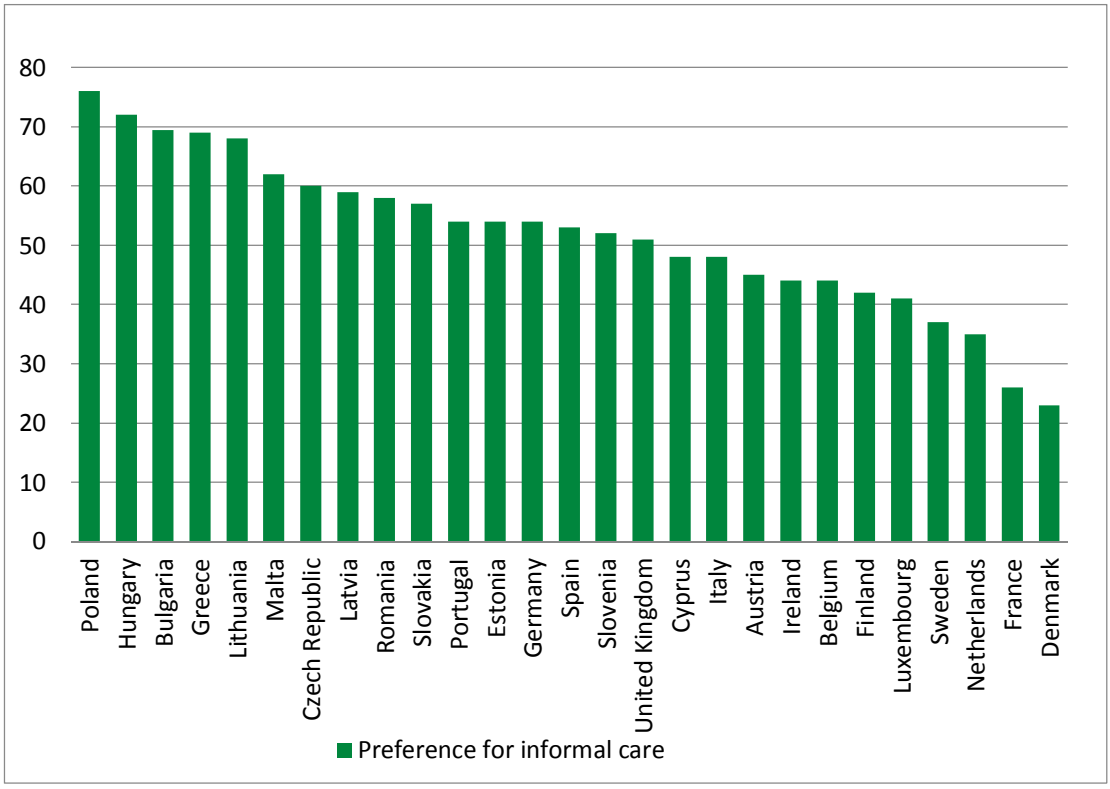
Figure 2. Full-time equivalent (FTE) formal and informal care for all children below the age of three, EU-27



Source: EU-SILC 2009 data, calculated by Van Lancker (2013).

Though we know of some cases of childcare and elderly care policy development following different paths,[31], at the country level the two care policy fields typically show similar patterns concerning generosity of public financing and the role of formal versus informal care provisions. Concerning preferences for informal provision of elderly care, at the welfare regime level, Figure 3 indicates that informal care is unambiguously the preferred option in post-socialist countries, while formal care is preferred in North-western Europe.

Figure 3. Preference for informal provision of elderly care in EU member states, 2007 (%)



Source: Eurobarometer survey on health and long-term care (European Commission, 2007)

The following three country cases illustrate the care-migration policy nexus: the liberal regime is represented by the UK, the Southern regime by Italy, and the post-socialist countries by Poland.[32]

9.4.1 Migrants on the market: Publicly funded and privately provided care in the UK

Affordability of care provision in the UK is means-tested and sustained through a wide range of monetary allowances, cash provisions, direct payments, tax reductions and insurance schemes. This allows the purchase of informal home care for children, the elderly and those in need of other forms of long-term care. The financing is decentralised through a mix of government grants to local councils, local taxation in the form of the council tax, and individuals' own resources. Care services in this system are publicly funded but privately provided; the care-providers' sector features both national and multinational chains as well as smaller agencies and businesses. An emphasis on monetary payments instead of institutional care makes non-parental informal care as important as formal care, and significantly reduces state expenditure on care.

This care model gave rise to a particular form of opening for migrant labour in the sector – the 'migrant in the market' model.[33] Most migrants are employed by private care providers, elderly care and childcare agencies, or through au pair programmes, and their share has been steadily increasing in the UK care sector. Migrants are more likely to find agency-based employment in

elderly care, while in childcare they are less likely to enter jobs in nurseries and day-care centres, tending to find employment instead as private childminders or nannies. This care market often pushes migrants who are ready to provide care services into very flexible, informal or even abusive working conditions.[34]

9.4.2 Migrant in the family: The legacies of familialism and informality in the Italian care regime

Italian labour and care policies have traditionally favoured the 'male breadwinner/female carer' model, relying on family – and particularly female family members – as the main source of care for children, the elderly and the sick. Thanks to some recent policy changes, the use of formal childcare is now high for children above the age of three, and in comparison with Europe as a whole, it is not low for children under three either. The expansion of institutional childcare is linked to increasing labour participation of Italian women and the absence of men from caring responsibilities.

Due to the rapidly ageing population and low fertility rates, a particular place in Italian care demand is occupied by geriatric care. The availability of an inexpensive migrant labour force and state cash support has made it possible for families, even those from lower social strata, to employ home carers. For the last 15 years, care for the elderly living at home has been increasingly provided by immigrants, generating a new carer profile of the '*badante*': a migrant woman typically working irregularly in the grey care market.[35] It is estimated that by the end of the 2000s, foreign workers constituted 70-90% of all workers in the Italian domestic care sector.[36]

On the part of the migrants, providing illegal work in the privacy of Italian homes makes them more competitive with other migrants and reduces their own efforts and expenditure on the lengthy and complicated process of regularisation. On the part of Italian households as employers, recruiting an illegal immigrant can cost as little as half the cost of a native domestic care worker, while the negotiation of work conditions and tasks is much easier with a migrant who fears being caught. Considering the high demand in Italian domestic care, migrant workers often become 'invisible' through engaging in live-in informal contracts; they live in their employer's house, have only one free day per week, and sometimes do not leave the house for weeks at a time. This form of work is preferred by first-time and irregular migrants, as it minimises their risk of running into the police and the need to arrange other aspects of their lives, such as accommodation or food. However, it leads to severe cases of exploitation, when their work spills into any hour of the day and night, and their food, freedom of movement, sleeping patterns and daily routines are heavily controlled by their employers.

9.4.3 Poland: Repositioning in the global care chain – the return of familialism and employment of a migrant domestic worker as a status symbol

The transformation of the Polish labour market in the last two decades has favoured sectors in which women were overrepresented, which has boosted female participation in the labour market. The country has experienced, however, a return of familialism – supported by the Polish state and the Catholic Church – that has reinstated women's main roles as mother and carer.[37] There are no guarantees for formal care for children under the age of three, making Polish parents and other relatives responsible for some 90% of care for this age cohort. The lack of institutional childcare prompts women to join the lines of the unemployed more often than their male colleagues, and makes their return to the labour market after parental leave more difficult.

Beside population ageing and the re-emergence of familialism as an ideological guideline for family and care policy, privatisation and the collapse of state-provided institutions of care (particularly homes for the elderly) have also shaped the development of the Polish care system. In addition, the employment of a domestic worker has become a status symbol that also plays an

important role in boosting care demand,[38] allowing middle- and upper-middle-class women not only to engage in more lucrative occupations, but also to maintain a certain lifestyle and spend time off work in more pleasant and personally rewarding endeavours. Thus, structural features of Polish care have become similar to the familialist Italian care regime of the past.

The migration aspects of the Polish care sector should be considered in relation to Poland's repositioning in the global care chain: the country has recently become both an emigration and an immigration country. While migrating Polish women still often use opportunities for informal employment in the domestic sectors of Germany, Belgium, Italy, Spain and Portugal,[39] the improving prospects of material well-being (partly from migration-generated income) have significantly increased demand for care and domestic services in Poland itself. Household services comprised 11% of all valid work permits to Poland in 2011, thus constituting the third largest occupational sector for migrants. The dual migratory status of Poland in the global care chain is clearly demonstrated by the increasing presence of Ukrainian domestic care workers: Ukrainians constitute by far the largest group among all immigrants in Poland, and 21% of them are engaged in domestic work.[40] Indeed, while Poland is at the centre of global care chains, Ukraine is experiencing increasing pressure on its care resources. The massive outflow of Ukrainian women to meet the needs of European care demand leads to their separation from their own families, including children and elderly people who will, in turn, depend on female domestic care within Ukrainian families.[41]

9.5 Decent employment of migrant and native domestic care workers requires strong state regulatory and monitoring capacities and developed gender equality policy

As cash-for-care schemes seem to provide a cheaper and more flexible alternative to formal and institutional care, we can count on the future expansion of these schemes, not only in liberal but also in other welfare regimes. This market-oriented policy, however, can only provide the desired positive aspects (freedom of choice, good quality of care service provisions and decent employment for care workers) together with decreasing gender inequalities if it ensures quality control, standard basic employment guarantees and a well-established legal institutional context to prevent either ethnic or gender discrimination. Thus, a particular focus on strong human resource policies and good quality employment relationships is crucial to provide decent jobs for (mainly female) care workers, including the large numbers of migrants but also for potential native employees.

Market-oriented care policy reforms can be risky in countries with moderate regulatory and monitoring capacities and less developed gender equality policy

The country cases presented above allow us to conclude that migration has been incorporated into national care regimes, giving rise to new care models such as 'migrant in the family' and 'migrant in the market'. The massive inflow of migrant female care workers (typically employed under substandard employment conditions and often employed informally) may apparently 'solve' the fiscally sustainable care regime puzzle in the short run. However, the smooth functioning of these market-oriented and migration-induced 'least resistance' policies implicitly assumes strong regulatory and monitoring capacities of states and developed gender equality policies.[42] Otherwise, they generate new forms of inequalities undermining the success of the socio-ecological transition.[43] Thus, specific policies have to be developed to guarantee not only the quality of privately provided services, but also the employment standards for the care providers themselves. A legal institutional context to prevent discrimination against and unfair treatment of care workers forms part of the fundamental condition of a fair market environment in the field of care.

Restrictive immigration policies in response to market-driven care demand are unlikely to support sustainable care regimes in receiving countries of care chains. If informality dominates labour transactions in the care sector and the state regulatory and monitoring capacities are weak, while structural pull factors of immigration remain, strict migration regimes in themselves will not block irregular migration into the domestic care sector, but will rather reinforce the vulnerability of migrant care workers.

As pull factors of migration dominate, restrictive immigration policies in themselves will not block irregular migration into the domestic care sector

The issue of immigrant care labour should be addressed in a complex and multi-layered way. The costs and benefits of the sending countries of transnational care chains should also be taken into consideration when the withdrawal of care increases the care burden on households without mothers. Therefore, cross-national welfare and social security provisions should be a priority in establishing legal and fair working conditions for both native and immigrant care workers. The issue clearly calls for the consideration of supranational management of the problem, and in this context the migration policy focus should be complemented by a broader approach of working rights for all (both native and immigrant) workers. Finally, decision-makers should be aware that transformative gender equality policy could modify (i.e. either enhance or countervail) the gender-specific impacts of care policies. Gender equality measures, such as political empowerment of women and enhanced work-life balance, can only drive sustainable care regime development and general gender equality if they address migrant women in the sector.

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Notes

[1] See Pascouau (2013), Carrera and Eisele (2014).

[2] Most studies of the care sector assume that care work consists of low-skilled jobs. Though we do not break this tradition of wording here, we are aware that the distinctive feature of care jobs are sometimes less related to the skill level than to the low prestige and unpleasant working conditions of these jobs; see Ruhs and Anderson (2010) and Van Hooren (2012). Lutz and Palenga-Möllenbeck (2010, p. 425) underline the high ratio of educated women among migrant care workers in Germany; in addition, they mention various specific skills required from care workers such as empathy, emotional intelligence, patience and high frustration tolerance capabilities. This issue is implicitly explored by Kureková *et al.* (2012) as well as Beblavý and Veselková (2014, p. 144), who describe "the surprisingly demanding nature of 'low-skilled' jobs".

[3] See OECD (2013).

[4] On the dynamics of changes in the EU population and labour force, see Veselková *et al*. (2014).

[5] 'Decent work' is certainly a normative concept (such as 'decent job' and 'decent employment' as well). However, we believe that it fits into the approach of the socio-ecological transition (SET) well. The concept was elaborated on by Amartya Sen, among others, and an important motive behind it was the refusal to dissociate economics from ethics (Sen, 2013). The issue of decent work has been on the global policy agenda since the ILO initiative of 1999 (see ILO, 1999).

[6] EU-15 refers to those EU member states that joined the EU before 2004 – namely, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, and the UK.

[7] Abrantes (2014).

[8] ILO (2010).

[9] OECD (2013, p. 82).

[10] In the NEUJOBS project, the NEMESIS model (New Econometric Model of Evaluation by Sectorial Interdependency and Supply), constructed by the ERASME team, is used to quantitatively explore the main socio-economic and environmental challenges for the EU in the framework of the SET without policy intervention and according to the global context.

[11] Schulz and Geyer (2013, p. 40); see also Schulz and Gstrein (2014).

[12] Particular childcare and elderly care policy measures in individual countries may have different impacts on migrant populations being attracted to these two segments of domestic care. Our study, however, concentrates on the structural and institutional features of welfare and care regimes, assuming that they are shaping childcare and elderly care policy choices similarly over the long run.

[13] Williams (2012).

[14] Orozco (2009).

[15] Wright and Bloemraad (2012).

[16] Da Roit *et al*. (2007).

[17] Ruhs and Anderson (2010).

[18] Triandafyllidou and Marchetti (2014).

[19] Cangiano and Shutes (2010).

[20] Van Hooren (2012).

[21] Esping-Andersen (1990).

[22] Ferrera (1996); see also Sapir (2006) and Hemerijck (2013).

[23] Tomka (2006).

[24] In order to avoid confusion, we have included variants of the welfare regime type names in the table.

[25] In the EU-28, the social-democratic regime is represented by Denmark, Finland and Sweden; the conservative Bismarckian regime by Austria, Belgium, France, Germany, Luxembourg and the Netherlands; the liberal regime by Ireland and the UK; the Southern regime by Cyprus, Greece, Italy, Malta, Portugal and Spain; and the post-socialist countries by Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia.

[26] Recent empirical studies (e.g. Jegermalm and Sundström, 2014) suggest that voluntary informal care can play a significant role even in the Nordic countries, but there it occurs in a way that is complementary to public care provision (and not as a substitution of formal care).

[27] See Williams and Gavanas (2008) and Van Hooren (2010).

[28] Eastern Partnership (EaP) countries are: Armenia, Azerbaijan, Belarus, Georgia, Moldova and Ukraine. (Eastern Partnership, Initiative was launched by the EU in May 2009 as an enhanced regional cooperation policy developed for Eastern European and Southern Caucasus states.)

[29] Kahanec *et al*. (2013).

[30] Szelewa and Polakowski (2008).

[31] For instance, for the Netherlands, see Van Hooren and Becker (2012).

[32] For a more detailed discussion of the country cases, see Fedyuk *et al*. (2014).

[33] Van Hooren (2012).

[34] Williams (2012).

[35] Da Roit *et al*. (2007, p. 658).

[36] See Van Hooren (2010) and Genet *et al*. (2013).

[37] Heinen and Wator (2006).

[38] Kindler (2012).

[39] Lutz and Palenga-Möllenbeck (2012).

[40] Duszczyk *et al*. (2013).

[41] Tolstokorova (2009); Lutz and Palenga-Möllenbeck (2012).

[42] Bartha *et al*. (2014).

[43] Weak monitoring capacities of the state imply that market-based policies in the care sector encourage the discussed specific demand features, thus boosting a secondary, informal and underpaid labour market segment with long working hours and substandard employment conditions. This type of development obviously contradicts the desired sustainability transformation strategy of the SET where productivity gains are translated into a reduction of working hours; see Veselková and Beblavý (2014).