

Recibido:11.03.2017. Aceptado:10.04.2017.

**BETWIXT CARE REGIMES: MIGRANT FILIPINAS IN EUROPE
AND THEIR SOCIO-SPATIAL (IM)MOBILITIES**

ENTRE SISTEMAS DE PROTECCIÓN SOCIAL: INMIGRANTES
FILIPINOS EN EUROPA Y SU (IN)MOVILIDAD SOCIO-ESPACIAL

ASUNCION FRESNOZA-FLOT

Centre for Migration Law/Institute for the Sociology of Law
Radboud University

ABSTRACT

With the aim to better understand how “care regimes” (that is, social protection systems) affect migrants’ lives, the present article draws from three separate studies on migrant Filipinas in Europe. The cases of three of these women unveil the important characteristic of the care regime in their country of origin and that in their respective receiving countries, which particularly shapes their lives. Interview data analysis suggests that insufficient care resources in the Philippines partly motivated these women’s migration as well as that of their offspring. In Europe, they experienced spatial and social class (im)mobilities due to the pro-undocumented migrant, family-focused, and transmigrant-friendly care regimes in their receiving countries, respectively France, Belgium and the Netherlands. Their encounters with the social protection systems “here” and “there” highlight their lives betwixt interacting care regimes in their social spaces.

KEYWORDS: care regimes, social protection, socio-spatial (im)mobilities

RESUMEN

Con el objetivo de comprender mejor cómo los “régimenes de cuidado” (es decir, los sistemas de protección social) afectan la vida de los migrantes, el presente artículo se basa en tres estudios separados sobre las migrantes filipinas en Europa. Los casos de tres de estas mujeres desvelan la importante característica del régimen asistencial en su país de origen y que en sus respectivos países receptores, que en particular moldea sus vidas. El análisis de los datos de las entrevistas sugiere que los insuficientes recursos de atención en filipinas motivaron en parte la migración de estas mujeres, así como la de sus hijos. En Europa, experimentaron movilidad espacial y de clase social debido a los regímenes migratorios pro-indocumentados migrantes en sus países receptores, respectivamente, Francia, Bélgica y los Países Bajos. Sus encuentros con los sistemas de protección social “aquí” y “allí” resaltan sus vidas entre régimenes de atención interactivos en sus espacios sociales.

PALABRAS CLAVE: régimenes de cuidado, protección social, socio-espacial (in)movilidad.

SUMMARY

I. INTRODUCTION

II. WOMEN'S MIGRATION AND CARE REGIMES

III. THE CARE REGIME IN THE PHILIPPINES: A BACKGROUND

IV. MIGRANT FILIPINAS IN EUROPE

V. ENCOUNTERS WITH THE CARE REGIMES “HERE” AND “THERE”

A. PRO-UNDOCUMENTED MIGRANT CARE REGIME IN FRANCE

B. FAMILY-FOCUSED CARE REGIME IN BELGIUM

C. TRANSMIGRANT-FRIENDLY CARE REGIME IN THE NETHERLANDS

VI. DISCUSSION AND CONCLUSION

I. INTRODUCTION

Studies on human migration demonstrate how people's needs and desires for a better life drive many of them to move from one place to another, thereby highlighting the link between migration and human security¹. In the United Nations Development Programme (UNDP) report of 1994, human security encompasses both "safety from such chronic threats as hunger, disease and repression" and "protection from sudden and hurtful disruptions in the patterns of daily life - whether in homes, in jobs or in communities"². In this line of thinking, migration can be interpreted as a way for people to seek elsewhere the security they cannot find in their societies of origin. To understand human (im)mobilities, it is therefore important to take into account the systems of social protection in migrants' countries of origin and of destination.

Social protection is not limited to social security, that is, formal programmes financed by "individual contributions" (pensions, health insurance, maternity and unemployment benefits) or "from tax revenues" (disability benefits, single-parent allowances, social pensions)³. It also includes "other forms of benefits and services (such as family benefits, universal health care services, and minimum-income provisions) that are generally available on a universal basis without regard to participation, contribution or employment status"⁴. In the context of migration, social protection is often called "care regime" to emphasize the ways in which the provision of care to different groups of people (children, unemployed, disabled, elderly...) are organized in a particular society⁵. "Care" refers in this article to the insurances, benefits, services and other entitlements that states provide to their citizens and non-citizens. Given its emphasis on "care", the concept of "care regime" seems useful to capture at the macro level how states are "caring for" ("carrying out caring work"⁶) their subjects or not. As MINDERHOUD remarks in the European context, "(s)ocial security systems are not only used to exclude irregular migrants but also for the exclusion of other less wanted immigrants"⁷. At the micro level, using "care regime" as a conceptual tool can also uncover how the lives of people are fashioned by the social protection systems of the states, notably concerning spatial and social mobilities (in short, the possibilities to move geographically and/or upward in a social class hierarchy).

To find out the ways states care for their subjects and how this influences the latter's lives, the present article examines the case of Filipino women migrants in France, Belgium and the Netherlands. Adopting a transnational perspective, it analyses these women's experiences of care regimes not only in their country of origin (the

¹Castles, S.; "International Migration at the Beginning of the Twenty-First Century: Global Trends and Issues". *International Social Science Journal* vol. 165, n° 52/2000, pp. 269-281. See also Hampshire, K.; Randall, S.; "Seasonal Labour Migration Strategies in the Sahel: Coping with Poverty or Optimising Security? *International Journal of Population Geography* vol. 5, n° 5/1999, pp. 367-385; Sana, M.; Massey, D. S.; "Seeking Social Security: An Alternative Motivation for Mexico-US Migration". *International Migration* vol. 38, n° 5/2000, pp. 3-24.

² UNDP; *Human Development Report*. Oxford University Press, New York. 1994, p. 23.

³Dupper, O.; "Migrant Workers and the Right to Social Security: An International Perspective. *Stellenbosch Law Review= Stellenbosch Regstydskrif* vol. 2, n° 18/2007, p. 224.

⁴ Ibid.

⁵Bettio, F.; Plantenga, J.; "Comparing Care Regimes in Europe". *Feminist Economics* vol. 1, 10/2004, pp. 85-113; Esping-Andersen, G.; *The Three Worlds of Welfare Capitalism*. Cambridge Polity Press. 1990.

⁶Thomas, C.; "De-constructing Concepts of Care". *Sociology* vol. 27, n° 4/1993, p. 649.

⁷Minderhoud, P.; "The "Other" EU Security: Social Protection". *European Journal of Social Security* vol. 8, n° 4/2006, p. 367.

Philippines), but also in their respective countries of immigration in Europe. It employs a bottom-up approach to unveil how these care regimes interact with one another at the individual level, thereby facilitating or impeding spatial and/or social mobilities of people.

To begin with, this article reviews related studies highlighting the links between migration (notably that of women) and care regimes, then provides a short background about the care regime in the Philippines. The next section presents the methodology adopted in this article and the three reference studies it draws from. The core of the article examines the cases of three Filipino migrant women to highlight the important characteristics of the care regimes in their respective countries of immigration at the same time as the care regime in the Philippines. These cases indicate that the care regimes “here” and “there” trigger in some cases spatial mobility (including that of children), and in some other cases spatial (and social) immobilities. Finally, the article ends with a reflection on the role of care regimes in the lives of women migrants, and suggests possible research lines for future studies on social protection systems in the context of migration.

II. WOMEN’S MIGRATION AND CARE REGIMES

The migratory movements of women from the Global South to the Global North are often interpreted through the prism of care. When “care resources”⁸ -social services and programmes that states provide to its subjects- are insufficient, the caring work of women becomes indispensable in many households. This “feminisation of survival”⁹ triggers and reinforces the migration of women on a global scale.

In their country of origin, women generally look after their family members in need (young, sick, elderly), and their large-scale emigration can engender a “care drain”¹⁰. This results in the reorganisation of care arrangements in their family, which is part of “global care chains”¹¹. In these chains of care, women migrants rely on the help of their female kin to take care of their household and children, while they themselves do the same for their women employers in their receiving country¹². In general, these women concentrate in the service sector, working as nannies, caregivers to the elderly, home/office cleaners, or health professionals¹³. Their paid care work is in many cases undeclared, as many women migrants have irregular migration status. Since care regimes interact with migration policies, the access of these women to State-offered care, as well as that of their male counterparts who also find themselves in irregular

⁸See Parreñas, R. S.; *Children of Global Migration: Transnational Families and Gendered Woes*. Stanford University Press, California. 2005.

⁹ Sassen, S.; “Women’s Burden: Counter-geographies of Globalization and the Feminization of Survival”. *Journal of International Affairs* vol. 53 n° 2/2000, pp. 503-524.

¹⁰Hochschild, A. R.; “Le Drainage International des Soins et de l’Attention aux Autres”. *Cahiers Genre et Développement* n° 5/2005, pp. 75-82.

¹¹Hochschild, A. R.; “Global Care Chains and Emotional Surplus Value”, pp. 130-146. In Hutton, W.; Giddens, A. (Eds.). *On the Edge. Living with Global Capitalism*. Jonathan Cape, London. 2000.

¹² Ibid.; this is also known as the “international transfer of caretaking” in Parreñas, R.S.; “Migrant Filipina Domestic Workers and the International Division of Reproductive Labor”. *Gender & Society* vol. 14, n° 4/2000, pp. 560-581.

¹³Ehrenreich, B.; Hochschild, A. R. (Eds.); *Global Women: Nannies, Maids and Sex Workers in the New Economy*. Metropolitan books, New York. 2003. Concerning the migration of health professionals, see Kingma, M.; *Nurses on the Move. Migration and the Global Health Care Economy*. Cornell University Press, Ithaca. 2006.

situation, is often limited¹⁴. Even if some social services are available, these migrants most often hesitate to avail themselves of those¹⁵ to avoid being discovered and deported afterwards.

Regular migrants, on the other hand, do have access to care regime, which makes them feel more secured than their irregular counterparts¹⁶. Their entitlements, notably to health care services, make some of them decide to spend their retirement in their country of immigration¹⁷. If their countries of origin and of immigration have a bilateral social security agreement, certain migrants return to the former and continue to enjoy there their retirement pension from the latter¹⁸. Since care regime is mostly gendered¹⁹, men and women in regular migration situation have differential access to it. For instance, in case of a birth of a child, women are generally entitled to longer parental leave than men, a situation similar to that of insider citizens in their receiving country.

Despite their different experiences with the care regime in their new land, migrants in regular or irregular migration situation take care of their family members in their countries of origin by sending them regular remittances and other material helps. Living in countries where education and healthcare are costly, their family members rely on their regular financial support to meet their needs. As a result, migrants work excessively to fulfil family obligations, which most often affect their health²⁰. This highlights how the care regime in the country of origin indirectly affects migrants even they are away from home. This care regime does not only influence their migration, but also structures their lives in their receiving country where another care regime shapes their well-being. Taking into account the differences between the care regime in the country of origin and that in the country of destination of migrants, we can therefore suppose that migrants live betwixt care regimes, meaning that their decisions and actions result from the interacting care regimes in their social spaces.

III. THE CARE REGIME IN THE PHILIPPINES: A BACKGROUND

The care regime in the Philippines started before the Second World War and progressively developed through different government acts. Its landmark development was the introduction of a universal medical care in 1969 by virtue of Republic Act 6111. This Medical Care Act was replaced by Republic Act 7875 of 1995 (National Health Insurance Act), which put into place a universal health coverage programme managed by the Philippine Health Insurance Corporation (Philhealth). Nowadays, aside from its non-contributory social services and programmes, the Philippine care regime

¹⁴Romero-Artuño, R.; "Access to Health Care for Illegal Immigrants in the EU: Should We be Concerned?". *European Journal of Health Law* n° 11/2004, pp. 245-272.

¹⁵Yoshikawa, H.; *Immigrants Raising Citizens: Undocumented Parents and their Children*. Russell Sage, New York. 2012.

¹⁶Author

¹⁷Author

¹⁸Holzmann, R.; "Bilateral Social Security Agreements and Pensions Portability: A Study of Four Migrant Corridors Between EU and non-EU Countries". *International Social Security Review* vol. 69, n° 3-4/2016, pp. 109-130.

¹⁹Kilkey, M.; Merla, L.; "Situating Transnational Families' Care-giving Arrangements: The Role of Institutional Contexts". *Global Networks* vol. 14 n° 2/2014, pp. 210-229.

²⁰Author. See also Benach, J.; Muntaner, C.; Delclos, C.; Menéndez, M.; Ronquillo, C.; "Migration and "low-skilled" Workers in Destination Countries". *PLoS Med* vol. 8, n° 6/2011. [DOI: 10.1371/journal.pmed.1001043](https://doi.org/10.1371/journal.pmed.1001043)

comprises three pillars: the Government Service Insurance System (GSIS), the Social Security System (SSS), and the Philhealth.

The GSIS was established through the Commonwealth Act No. 186 in 1936, and was strengthened through Republic Act No. 8291 of 1997²¹. Except for certain groups of government workers²² and for those without regular working hours and fixed monthly salary, this institution covers all public employees. It requires both the employee and his/her employer government agency to shoulder the monthly contribution equivalent to 21 percent of the former's monthly salary: 9 per cent is paid by the employee and 12 per cent by his/her employer²³. This monthly contribution entitles employees to many advantages including life insurance and "retirement, separation, unemployment, sickness and disability benefits"²⁴. (S)he can also avail of certain loans such as salary, emergency, pension and housing loans.

The SSS, on the other hand, was founded in 1954 through Republic Act No. 1161 and has targeted private and informal sector workers and their families. Membership in it is compulsory for the following groups: employers (e.g. foreign governments, international organizations and their instrumentalities such as embassies), employees (seafarers, household helpers, private sector employees), and self-employed persons earning at least 1,000 pesos per month (e.g. farmers, entrepreneurs, actors and actresses)²⁵. Voluntary membership is also possible for separated members (i.e. members who became unemployed), Overseas Filipino Workers (OFWs), and non-working spouses of SSS members. The employer pays 7.37 per cent and the employee 3.63 per cent -that is 11 per cent in total- of the former's salary, for a total amount not exceeding 16,000 pesos per month²⁶. Voluntary members are also required to contribute 11 per cent of their monthly earning "declared at the time of registration"²⁷. In terms of benefits, SSS provides advantages similar to those of the GSIS, such as retirement pension and disability support. Both GSIS and SSS adherents are mandatory members of the Home Development Mutual Fund (HDMF), widely known as the Pag-IBIG Fund established in 1978 through Presidential Decree No. 1530²⁸. This fund provides its members access to its housing programs and loans at affordable rates, and also welcomes voluntary members aged 18 to 65 years old.

However, despite the existence of GSIS and SSS, many Filipino workers remain outside of these systems: for example, only 28 per cent of the employed Filipino population in 2007 were members of them²⁹. This can be attributed to the fact that many workers with low monthly earnings cannot afford to pay the membership fee and monthly

²¹See "GSIS Mandate" at <http://www.gsis.gov.ph/about-us/gsis-mandate-and-functions/>

²²"members of the Judiciary and Constitutional Commissions who are covered by separate retirement laws; contractual employees who have no employee-employer relationship with their agencies; uniformed members of the Armed Forces of the Philippines and the Philippine National Police, including the Bureau of Jail Management and Penology and the Bureau of Fire Protection" (ibid.)

²³ Ibid. See also Manasan, R. G.; "A Review of Social Insurance in the Philippines". *Philippine Journal of Development* vol. XXXVI, n° 2/2009, pp. 47-68.

²⁴ Ibid.

²⁵For details, see the website of the SSS at:

<https://www.sss.gov.ph/sss/appmanager/pages.jsp?page=coverage>

²⁶"Schedule of contributions":

<https://www.sss.gov.ph/sss/appmanager/pages.jsp?page=scheduleofcontribution>

²⁷For other members such as OFWs and spouse of an SSS members, see:

<https://www.sss.gov.ph/sss/appmanager/pages.jsp?page=scheduleofcontribution>

²⁸"The Birth of the Home Development Mutual Fund" at <http://www.pagibigfund.gov.ph/abouthdmf.aspx>

²⁹ Manasan; Op.cit.

contributions. The establishment of Philhealth in 1995 aimed to address this problem. To do so, it centralised the country's health insurance system by integrating into its administration the health insurance sections of GSIS and SSS in 1997 and 1998 respectively. It also absorbed in 2005 the health insurance section of the Overseas Workers Welfare Administration, an agency that "provides (Filipino) migrants with cultural services, social security, as well as judicial, social, employment and remittance transfer assistance"³⁰. Since Philhealth membership was not obligatory, some minority groups in the Philippine society remained uncovered. In 2013, Republic Act 10606 established a universal and mandatory health care coverage, thereby making Philhealth easily accessible to indigents. Aside from individual contributions, Philhealth receives subsidies from the government, which helps it attain its aim. As a result, its coverage has been increasing steadily from 82 per cent of the country's population in 2011³¹ to 92 per cent in 2015³².

These important developments in the care regime of the Philippines did not affect the respondents in the present study, as they migrated to Europe prior to the introduction of the new law in 2013. Instead, they experienced the insufficient care resources in the country prior to that date, notably in terms of health care.

IV. MIGRANT FILIPINAS IN EUROPE

The cases analysed in this article stem from three separate studies: the first focused on Filipino migrant children and youth reuniting with their parents in France, the second examined children and childhood in ethnically mixed families in Belgium, and the third investigated marital break-up experiences of migrant Filipinas in the Netherlands. Although they had different aims and scope, these three studies were similar in that they mainly used qualitative data-gathering methods such as semi-structured interviews and observations. The data collected during these studies provide insights on the way the care regimes in the country of origin and in the receiving country of Filipino women affect their social and spatial (im)mobilities.

The three studies generated 56 interviews of the target migrants, among which 46 were women. This numerical dominance of women reflects the reality of the Filipino migrant population in Europe, which is composed mainly of women. These migrant women are concentrated in the service sector and generally reside in urban areas. The main destinations in Europe of these migrants and their male counterparts are Italy, United Kingdom, and Greece³³. France, Belgium and the Netherlands are also part of the top 15 destinations of these migrants (*ibid.*, see Table 1). The Filipino population in each country is generally structured around places of worship, mainly Catholic³⁴, where I carried out participant observations and met study respondents.

³⁰Author

³¹World Health Organisation; Department of Health; "Health Service Delivery Profile. Philippines". 2012, p. 2. http://www.wpro.who.int/health_services/service_delivery_profile_philippines.pdf.

³²See page 8 of the PhilHealth's "Annual Report 2015" at:

https://www.philhealth.gov.ph/about_us/annual_report/ar2015.pdf.

³³Commission on Filipinos Overseas (CFO); "Stock Estimate of Overseas Filipinos as of December 2013". 2014. <http://www.cfo.gov.ph/images/stories/pdf/StockEstimate2013.pdf>.

³⁴Author.

Table 1. Top destinations in Europe of Filipino migrants (as of December 2013)³⁵

Rank	Country	Population	Total
1	Italy	271,946	835,864 (equivalent to 97 per cent of the total Filipino population in Europe)
2	United Kingdom	218,126	
3	Greece	61,716	
4	France	48,018	
5	Germany	47,214	
6	Spain	42,804	
7	The Netherlands	21,789	
8	Switzerland	20,910	
9	Cyprus	19,948	
10	Norway	18,088	
11	Ireland	13,976	
12	Austria	13,636	
13	Sweden	12,938	
14	Belgium	12,419	
15	Denmark	12,336	

The reasons why the 46 women interviewed migrated are mostly family- and work-related (see Table 2). Many study participants in France migrated to reunite with their migrant parents, whereas the persons I interviewed in Belgium and some respondents in the Netherlands migrated to join their (future) husbands there. Other migrants came to Europe to find work and support their family. Similarly, many migrants who arrived to form a family tried afterwards to find work to be able to support financially their natal families in the Philippines³⁶.

Table 2. The migrant Filipinas interviewed

Number	Study 1: France	Study 2: Belgium	Study 3: The Netherlands
	11	16	19
migration status	8 (regular) 3 (irregular)	16 (regular)	19 (regular)
average age	24	46	61
Education	7 (tertiary) 4 (secondary)	3 (postgraduate) 11 (tertiary) 1 (secondary) 1 (elementary)	2 (postgraduate) 14 (tertiary) 3 (secondary)
year of immigration	4 (1990s) 7 (2000s)	6 (1980s) 7 (1990s) 3 (2000s)	1 (early 1960s) 3 (1970s) 5 (1980s) 9 (1990s)

³⁵Ibid.³⁶Author.

			1 (early 2000s)
average duration of residence (in years)	10	20	33

In the following sections, I examine the cases of three migrant Filipinas. In the first case, differences in health care regimes “here” and “there” drove the migrant parents of a young Filipino woman to make her follow them in their receiving country. The second case appears representative of migrant Filipinas in Belgium, who, even when highly educated, usually decide to be housewives or work part-time (often undeclared). Finally, the third case tells us the peculiar story of a Filipino migrant interviewed in the Netherlands who formerly resided in Australia and experienced movements between these two countries. Aside from these case studies, I also draw from my other interviews to enrich my analyses of the impact of care regimes on the lives of migrants.

V. ENCOUNTERS WITH THE CARE REGIMES “HERE” AND “THERE”

Filipino migrant respondents have different migration histories that provide information on the important role care regime(s) play in migrants’ decision-making. It is part of their imaginaries as they search for better living conditions.

A. PRO-UNDOCUMENTED MIGRANT CARE REGIME IN FRANCE

I have a heart problem and they [doctors] would like to do surgery on me, but my parents did not like because I would be in coma for a week. There is a hole [in my heart]; it is congenital. My parents told me to come here [France] to be [medically] treated and that here was better. When I arrived here, we found out that I did not need to be operated, which my parents found very good. They told me that in the Philippines, the doctors wanted to immediately do surgery on me because my parents were abroad, they wanted money. Here, I only need maintenance, check-up every two years.

This vignette narrates why Tina (20 years old and university student) migrated to France in 2004: to access quality and affordable health care. Her parents migrate first to France and worked in the domestic service sector. Tina and her sister grew up with her maternal grandmother, and reuniting with her parents in France did not cross her mind. Her parents’ monthly remittances sustained their basic needs including medical care. Having no health insurance, they used cash to pay their medical and health-related expenses. The diagnosis of her congenital heart disease and the costly surgery she was recommended to undergo in the Philippines changed her life trajectory. In spite of their irregular migration status, Tina’s parents decided to make her migrate to France using the tourist visa route³⁷. Tina remembers what her parents told her at that time:

Here [in France], people have [health] card. In our country, not. My parents told me that those without papers here are free of charges [in terms of access to healthcare services].

Tina’s remarks partly explain the reason behind the large number of Filipino migrants in irregular situation in France: 37,880 of 48,018 in 2013³⁸. Unlike other migrant-receiving countries, France’s *Aide Médicale d'Etat* (AME) or State Medical Aid covers medical

³⁷Author.

³⁸CFO. Op.; cit.

and hospitalisation costs (except thermal cures and fertility treatments) of its target beneficiaries, that is, migrants in irregular situation. The conditions to access the AME include at least three months of residence and earning less than 8,653.16 euros per year per person (for those living in mainland France) or 9,631 euros (for those residing in French overseas departments)³⁹. Article L251-1 of the French Code of Social Action and Families states that aside from migrants in irregular situation, people who are administratively detained in France can also benefit from the AME regardless of their place of residence. In addition, Article L161-1 of the Social Security Code indicates that the rights to medical care through AME is not limited to migrants themselves but extend to their immediate family members under their care: for example, children less than 16 years old, and those who are students until the age of 20.

Thus, it is not surprising that Tina's parents immediately decided to make their daughter come to France: they knew that their daughter (like them) would be entitled to free medical care. At the time of her interview, Tina was applying to regularise her situation in France through the help of a migrant association while finishing her university studies. Thanks to the medical care she received, she was not complaining of any health problem. She confided that her parents were planning to make her younger sister follow them soon to France using also a tourist visa.

B. FAMILY-FOCUSED CARE REGIME IN BELGIUM

Before, I had no job, and my husband was the one working. His salary increased, because he was supporting me. I have no [declared] job. But once I work and it is declared, his salary will decrease, it will be deducted.

This experience of Anita (40 years old and mother of one) is not exceptional, as many Filipino migrant women I interviewed in Belgium decided not to engage in the labour market. This can be partly attributed to the Belgian "dependent spouse allowance" (*quotien conjugal*) scheme for married or legally cohabiting couples, which allocates 30 per cent of the annual income of the family to the unemployed partner. According to the Belgian Income Tax Code of 1992, a couple in which one partner is working full time and the other part-time can also benefit from this scheme provided that the latter's income does not exceed 30 per cent of the total professional revenue of the couple with 6,700 euros as basic amount. For the 2017 tax assessment in the country, this amount has been indexed 10,490 euros. Such a system prompts the Belgian husbands of the respondents to encourage the latter to be full-time housewives.

Desiring to be "good wives" and "good mothers", 11 of the women interviewed heeded their Belgian husbands' advice and became either full-time housewives or undeclared part-time domestic workers⁴⁰. Only a few respondents (5) engaged in declared full- or part-time work. We see here how the Belgian social policy promotes not only legal unions, but also the sole-breadwinner model of family instead the dual-earner one. This reinforces women's "dependency on marriage"⁴¹, not only in economic terms but also concerning health care. As dependents of their husbands, stay-at-home or low-income respondents are covered by their partner's health insurance fund. To be qualified as "dependents", these women should live in the same house as their insured partner and

³⁹See the website of the French administration: <https://www.service-public.fr/particuliers/vosdroits/F3079>.

⁴⁰Author.

⁴¹Komter, A.; "Hidden Power in Marriage". *Gender & Society* vol. 3, n° 2/2007, p. 135.

not earn more than 2,326 euros gross per quarter⁴², an additional impetus not to engage in the labour market.

Staying at home or not, most of the women interviewed had tertiary-level education and/or socially valorized professions in the Philippines prior to their migration. Anita, for example, had a university degree in education and had worked as a secondary school teacher in the Philippines, but at the time of the interview was a part-time, undeclared house cleaner. Except in one case in which the woman interviewed found a job directly related to her educational background, respondents like Anita obviously underwent a downward professional mobility. Women interviewed who decided not to work experienced spatial immobility as their life became mainly concentrated in the realm of home.

In spite of this, the respondents seemed satisfied with their lives in Belgium. During my recent fieldwork in the country, one migrant Filipina I met who was a health professional in the Philippines and worked as a chambermaid in a hotel in Flanders told to me: “my salary is much higher than those of my colleagues in the Philippines, and on top of that I have health insurance, pension plan, paid leave, and a yearly bonus”. This highlights the role the care regime in Belgium plays in the lives of the respondents in legal unions with Belgian men: on one hand, it induces socio-spatial (im)mobilities, but on the other hand it provides incentives to its beneficiaries. These incentives, which migrant Filipinas could not easily enjoy in their country of origin, allow them to make sense of their post-migration situations. The “strong notion of familialism”⁴³ in Belgian social policy, which governs its care regime, undeniably structures their familial and professional lives.

C. TRANSMIGRANT-FRIENDLY CARE REGIME IN THE NETHERLANDS

Many Filipino migrants have had the experience to live in one or more countries, which stems from their “stepwise migration”⁴⁴ moving from one country to another in order to attain their desired destination country, or in other cases to achieve their family-focused project(s). The socio-spatial mobilities of these “transmigrants”⁴⁵ are often shaped by the care regime in their former and/or present country of residence, as the case of a migrant Filipinas in the Netherlands illustrates below.

I am entitled to carer’s allowance, not pension, because he [her Dutch ex-husband] is on pension, and I have my pension already. I cannot receive two pensions, but for allowance, you are entitled for allowance in Australia. Because when my sister was sick, I went there. [...] They [staff of the Department of Human Service] say, “fill in this form, you are entitled for carer’s allowance”...and 55 dollars a week. [...] and on top of that by December or July, every six months you get a whole month’s pension.

⁴²CLEISS; “Le Régime belge de Sécurité sociale (salariés)”. 2016.
http://www.cleiss.fr/docs/regimes/regime_belgique_s2.html.

⁴³ Ibid.

⁴⁴ Paul, A. M.; “Capital and Mobility in the Stepwise International Migrations of Filipino Migrant Domestic Workers. *Migration Studies* vol. 3, n° 3/2015, pp. 438-459.

⁴⁵ Glick Schiller, N.; Basch L. G.; Szanton Blanc, C.; “From Immigrant to Transmigrant: Theorizing Transnational Migration”. *Anthropological Quarterly* vol. 68, n° 1/1995, pp. 48-63.

These remarks of Elisabeth (66 years old) reflect her connections with two care regimes: one in the Netherlands where she was residing with her Dutch husband at the time of the interview, and the other in Australia where she was living prior to marrying him. Elisabeth migrated to Australia from the Philippines at the age of 35 and later on became an Australian citizen. She worked there as a government employee during 15 years, but retired early due to a work-related accident that led her to apply for a disability pension. When she moved to the Netherlands in 2004, she was able to receive her Australian pension directly in her Dutch bank account thanks to the Social Security Agreement between Australia and the Netherlands that started in April 2003. However, she was surprised how her pension was treated differently in both countries: “you receive pension [here in the Netherlands] from the government but that pension is taxed, but there (in Australia), (disability) pension is not taxed”. Since Elisabeth was already receiving a pension, she was not entitled to the Dutch state old-age pension (AOW), which “provides all residents of the Netherlands aged 65 and over with a flat-rate pension benefit that in principle guarantees 70 percent of the net minimum wage”⁴⁶.

However, Elisabeth appreciates that she can receive what she calls “carer’s allowance” in the Netherlands as a caregiver to her Dutch husband. What she meant by “carer’s allowance” is the “personal budget” (*persoonsgebondenbudget*) that her husband obtains from the Dutch government. “Carer’s allowance” here does not refer to the Australian “carer’s allowance”, that is, “(a)n income supplement for carers who provide additional daily care and attention for someone with a disability or medical condition, or who is frail aged”⁴⁷. Rather, Elisabeth means the “personal budget” (*persoonsgebondenbudget*) that her husband obtains from the Dutch government, which mainly aims “to empower consumers by giving clients more control over their care”⁴⁸. Like “(a)bout half of all budgetholders” in the Netherlands who “pay informal caregivers”⁴⁹, Elisabeth’s husband resorts to his wife’s care work instead of seeking the aid of a homecare agency. Hence, economically speaking, Elisabeth has a stable sources of income in the Netherlands: her Australian pension and her “carer’s allowance” from her husband.

Aside from this, she was compensated in 2011 by the Australian care regime for taking care of her sister (an Australian citizen) who was suffering from a grave sickness. This compensation came in the form of “carer’s allowance”. During five months, Elisabeth looked after her sister in Australia while her Dutch husband stayed in the Netherlands. When her marriage broke up in 2016, she confided to me that she would return to Australia to spend her old age there, taking into account the country’s favourable social security system, offering among others carer’s allowance and non-taxed disability pension. It is evident that Elisabeth’s spatial mobility between Australia and the Netherlands stems from the intersecting care regimes in these countries.

⁴⁶Ministerie van Sociale Zaken en Wergelegenheid (SZW); The Old Age Pension System in the Netherlands. Rijksoverheid, The Hague. 2008, p. 7.

⁴⁷Department of Human Services; “Carer allowance”.

<https://www.humanservices.gov.au/customer/services/centrelink/carers-allowance>.

⁴⁸Wiener, J. M.; Tilly, J.; Cuellar, A. E.; Consumer-directed Home Care in the Netherlands, England, and Germany. American Association of Retired Persons (AARP), Washington. 2003, p. 30.

⁴⁹Ibid., p. 37.

VI. DISCUSSION AND CONCLUSION

The three cases examined in this article highlight the important characteristics of care regimes that shape the lives of migrant Filipinas in Europe: the insufficient resources offered by the care regime in their country of origin; and the pro-undocumented migrant, family-focused, and transmigrant-friendly care regimes in their receiving countries. These characteristics interact with one another in shaping the spatial and social class mobilities of migrant Filipinas in Europe.

The free health care services available in France for migrants in irregular situation open doors for the migration of some of their children to access medical care and also to reunite their family. The difficulty that these migrants' family members encountered in the Philippines to obtain quality health care at an affordable cost when the country had not yet introduced a universal healthcare coverage sometimes influenced their decision to make their children migrate. This confirms the present article's hypothesis that the lives of migrant Filipinas are betwixt interacting care regimes. The quest for security and for better social protection drives them and their family members to move and settle from one society to another. It is also observable that care regimes can engender spatial and social class immobilities, as the case of some migrant Filipinas in Belgium indicate. The Belgian tax system and health insurance system provide supports to single-breadwinner households, which motivates couples involving migrant Filipinas not to follow a dual-earner family model. Those who decide to work appreciate the benefits they can access in Belgium in comparison with those in their country of origin. Comparing care regimes "here" and "there"; migrant Filipinas easily identify which social protection system offers them more advantages than the other. This is what the case of a Filipino woman in the Netherlands illustrated: the carer's allowance and non-taxed disability pension in her former country of residence (Australia), which are not available in her present country of immigration, influenced her decision where to spend her old age. Here, we see again the lives of migrant Filipinas being betwixt two care regimes.

Moreover, the way social protection system operates in each country examined in the present article reflects the views of states about human security. In the Philippine pre-2013 context, health care coverage was not mandatory, and the State was acting in a neo-liberal fashion, letting its subjects responsible for finding social protection for themselves and their families. This alimented the overseas migration tradition in the country; parents and children alike took the migration route towards the place they believed would offer them an economically and socially secured life. In Europe, the receiving countries of migrant Filipinas behave differently, reflecting their values and ideology. By offering free health care services to undocumented migrants, France is in line with the Article 8 of the European Convention on Human Rights, which prohibits discrimination "on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status"⁵⁰. In Belgium, the care regime reflects the importance this country grants to legal unions and the centrality of the family in its social policy. This reinforces the traditional gendered family model in which one partner (usually the woman) stays at home doing reproductive and emotional labour, whereas the other engages in the labour market. In the Netherlands, the case presented in this article indicates how the Dutch

⁵⁰European Courts of Human Rights; European Convention on Human Rights. Council of European, Strasbourg. p. 12. http://www.echr.coe.int/Documents/Convention_ENG.pdf

state values regulated free movements of people across national borders. Through bilateral social security agreements with other countries, it facilitates the transnational lives of its citizens and non-citizens.

Furthermore, based on the cases analysed in this study, it is important to note that care regimes do not function alone, but are connected to and dynamically interacts with other regimes such as those governing migration. As observed above, migrants in regular situation and with declared works in Belgium are entitled to advantages such as paid parental leave and holiday allowance, which are not accessible to their undeclared working and undocumented counterparts. Such differential treatment of migrants based on their migration status indicates the existence of a “hierarchy of stratified rights”⁵¹ in Europe. This hierarchy and the gendered as well as transnational aspects of care regimes in this region need to be further investigated through cross-country comparisons or longitudinal studies of migrants’ access to such regimes, which can help us to better comprehend migrants’ subjectivity and agency in highly developed economies.

⁵¹Kraler, A.; Civic Stratification, Gender and Family Migration Policies in Europe. International Centre for Migration Policy Development, Vienna. 2010.