11

Swedish Retirement Migrants in Spain: Mobility and Eldercare in an Aging Europe

Anna Gavanas and Ines Calzada

Introduction

In the neoliberal era, privatization and internationalization are of crucial importance to conditions for eldercare in the European Union (EU), including Sweden, which has one of the highest rates of public provision in Europe. Swedish retirees are part of a growing stream of older Northern Europeans who migrate to Southern Europe, especially to coastal areas in Spain. There are about 90,000 Swedish citizens living in Spain

A. Gavanas (✉)
Social Anthropology and Gender Studies, Remeso/ Linköping University, Linköping, Sweden
e-mail: anna.gavanas@liu.se

I. Calzada
Institute of Public Goods and Policies of the Spanish National Research Council, Madrid, Spain
e-mail: ines.calzada@cchs.csic.es

M. Kilkey, E. Palenga-Möllenbeck (eds.), *Family Life in an Age of Migration and Mobility*, Migration, Diasporas and Citizenship,
DOI 10.1057/978-1-137-52099-9_11

(Hedlund 2011). During the retirement life course phase, circumstances change, highlighting that retirement is dynamic rather than one distinctive phase. When Swedish retirees in Spain become increasingly in need of eldercare, they find themselves in a country with one of the lowest rates of public provision in Europe, and are left with a patchwork of private solutions. The pieces in the 'elderly care puzzles' (Szebehely 2004) that form the patchwork of care around older persons depend on the accessibility and affordability of a number of options: public/private provision, social/volunteer networks, family situation, as well as the preferences and conditions of different groups of older persons. Gender, health, socio-economic conditions, as well as Swedish and Spanish provision of health- and eldercare influence the mobility of international retirement migrants (IRMs), especially in the case of widows and single women with low income. This chapter discusses the conditions for mobility and independent aging in relation to a wide range of Swedish IRMs in Spain. We illuminate the mobility of IRMs as Europeans in the context of Freedom of Movement, and its limits. Below we outline the welfare and migration context of Swedish retirement migration to Spain. Subsequently, we analyze the economic, gendered and health factors that circumscribe the mobility and immobility of different IRMs.

Mobilities, Eldercare and Care Regime

In the words of Zygmunt Bauman, mobility is one of today's highest values, and the freedom to move is an unequally distributed commodity which has become a main stratifying factor. Conversely, immobility or 'locality' is a sign of social deprivation and degradation (Bauman 1998: 2): '[T]he dimension along which those "high up" and "low down" are plotted in a society of consumers, is their *degree of mobility*—their freedom to choose where to be' (Bauman 1998: 86). However, aging has traditionally been discursively equated with the opposite of mobility, although lifelong experience of tourism and traveling has made today's older generation more mobile (Blaakilde and Nilsson 2013: 11).

John Urry (2007: 11) suggests that international retirement migration—'post-employment travel and the forming of transnational

lifestyles within retirement'—represents one of 12 main mobility forms in the contemporary world. Social networks, inexpensive travel and access to communication technologies are key resources for IRMs to exercise mobility. IRM mobility also entails 'exit mobility' (Urry 2007: 201) if 'the going gets tough', which our research identifies as the possibility to relocate to accessible, affordable and acceptable arrangements for living and care. In other words, we argue that, contrary to the story of cosmopolitan IRMs in their active retirement age living beyond and across States, the Swedish and Spanish welfare and care regimes are crucial to framing the experiences of IRMs. Here, variations in the degree of mobility among IRMs occur when they reach dependency on eldercare.

Previous research on IRMs (Huete and Mantecón 2013) has often framed Northern European migrants as a case of privileged migration. In contrast, our study confirms that contemporary IRMs span a wide range of socio-economic positions and motivations (Blaakilde 2013), and investigates the ways in which mobility and independent aging is gendered and classed. Good health and strong finances are prerequisites for mobility in later life (Nilsson 2013: 28), and so is access to familial and social networks, as well as access to affordable and adequate eldercare services. Due to their limited access to formal institutions (because of, e.g., limited language skills, access to information and rights), migrants are in need of informal social networks. Given that IRMs' access to resources varies and that gender, health and family situation cut across these factors within the Swedish and Spanish welfare and care regimes, how do different IRMs fare in the contemporary age of mobility?

The transnational lives of Swedish IRMs can be situated within and between the Swedish and Spanish welfare and care regimes, which involve different ways of distributing the responsibility of eldercare between state, market and family (Esping-Andersen 1999; Korpi and Palme 1998). Spain has been described as a familialistic care regime and Sweden as a universalistic one (Anttonen and Sipilä 1996; see also Widding, Chap. 8, this volume). Both regimes are going through important changes, partly reflecting policy concerns around population aging and the upcoming 'care crisis' in aging Europe.

Regarding family institutions, Kohli et al. (2008: 170) propose the existence of a North–South gradient, 'with the Scandinavian countries generally having the least traditional family structure, the Mediterranean

countries (Spain and Italy more so than Greece) the most traditional ones [meaning male breadwinner centered], and the continental countries lying somewhere in-between'. In Europe, Mediterranean countries have the highest levels of intergenerational cohabitation and spatial proximity of family members; care activities carried out by family members are more time intensive in Southern Europe than in other European countries (Attias-Donfut et al. 2005, 2008), and adult children provide personal care to their elders (dressing, bathing, eating) much more frequently than in the Nordic or Continental countries, where professional service providers take on these tasks (Brandt et al. 2009). All these family and welfare institutions are gendered in that women represent the bulk of the caregivers whether paid or unpaid, and so too are social rights gendered (Lister et al. 2007). The Southern/Mediterranean welfare state is said to be characterized by a fragmented system of income maintenance that combines generous contributory programs (pensions, unemployment) with severely underdeveloped areas (basic security, family and care policies), differentiation following the corporatist tradition in the field of health care (with their universal National Health Services), and a mix of public and private providers of welfare in which unpaid family care constitutes the main insurance for risks not covered by public welfare.

In 2007, the so-called Dependency Law introduced a radical shift in the Spanish welfare state from previous small means-tested programs toward more public and comprehensive provision of care, increasing the role played by the State in the care area and extending the coverage of public protection to all dependent people (i.e., to all residents living in Spain for longer than five years who could certify a certain level of dependency). The original intention with the 'Dependency Law' was to create a care program similar to those in social-democratic welfare states—funded by general taxation and granting universal protection in the form of services and cash transfers but prioritizing direct service provision. However, with the arrival of the economic crisis in 2008, the central government took measures to scale back the implementation of the 'Dependency Law'.

The Swedish IRMs who live in Spain seasonally or permanently have a background in a welfare- and care regime with much more extensive coverage of publicly funded eldercare. In Sweden, the great expansion of public eldercare occurred in the 'golden years' of the 1960s to 1970s.

However, the Nordic universalistic care regime has been going through significant changes since the 1980s, with New Public Management inspired reforms and processes of retrenchment, familialization and marketization (Meagher and Szebehely 2010, 2013). Marketization in Sweden has been paralleled by a decline in the coverage of publicly funded services, as public resources for eldercare were reduced by 14 % between 1990 and 2000 (Szebehely 2011). The increased privatization of eldercare in Sweden has been twofold: in terms of an increased use of private domestic services (tax reduced since 2007) among older people, as well as an increased use of privately provided, although generously State funded, eldercare services (Gavanas 2013a, b). It has become an important characteristic of European welfare states (including the Swedish and Spanish) for migrant domestic workers in both formal and informal markets to fill the gaps in demand for domestic services, child- and eldercare (Österle et al. 2011; Simonazzi 2009; Williams and Gavanas 2008). As we can see across Europe, with an increasing scale and proportion of domestic services outsourced to the market (including eldercare), the cost of care and domestic services varies with the cost of labor (Williams and Gavanas 2008). In Sweden it has been demonstrated that since the extent of demand for privately funded domestic services is highly price sensitive, the flexibility and low cost of informal services competes with formal alternatives, unless highly subsidized by state policies (Gavanas and Mattsson 2011). As universalism is threatened, the relative sizes of the different pieces in the 'care puzzles' of Swedish eldercare are changing. Some care responsibilities have been redirected toward families, increasing unpaid care work by family members, particularly working-class women (Brodin 2005; Ulmanen 2013).

Our Study: Methods and Material

For this chapter, we draw on a study[1] in which we have interviewed 80 IRMs, 120 workers and entrepreneurs who carry out IRM-related services (such as cleaning, handyman work, care and gardening), as well as 20 experts (representatives of key organizations and public authorities) in 24 villages and towns located in two of the three main destination regions

for Swedish IRMs: the Southern coast of mainland Spain ('Costa del Sol' in the region of Andalucía) and the Canary Islands. Among service providers, we undertook 56 interviews with workers/entrepreneurs who deal with the care needs of Swedish IRMs. They were 13 public social workers at different levels of social services for elderly people, 4 social workers at private hospitals oriented to northern Europeans and care service companies, 15 entrepreneurs and workers in private care companies (private elderly homes and care service companies), and 24 workers hired directly by Scandinavian IRMs (formally or informally).

Our large number of interviewees seek to encompass the large variation in the conditions and motivations of IRMs. We can expect that this variation is also translated into the range and type of services that IRMs demand, and henceforth in the characteristics and constellation of service provision. The decision to carry out the fieldwork in two different Spanish regions (and a range of IRM destinations within these) is guided by two aims: firstly, to maximize variation among our interviewees, and secondly, to establish the importance of the welfare and labor contexts in shaping the options and strategies of IRMs concerning the provision of services, since most welfare services in Spain are under the responsibility of the regions. By means of semi-structured interviews (Bernard 2006), we used interview guides with open-ended questions that allow for follow-up questions. We thus posed comparable and corresponding questions to our interviewees to get at the everyday interrelations, negotiations, practices, cultural values and presumptions of actors impacted by macro level processes. What are the strategies, experiences and conditions of various groups of IRMs? In what ways are their trajectories conditioned by access to various resources, welfare, especially pension, and migration policies, as well as different norms, preferences and habits around consumption, service and care?

Interviewees were selected through thematic sampling, ensuring maximum variation along relevant parameters, such as age, gender, family situation, socio-economic background, living arrangements and length/timing of migration, national background and the type of service provided, the work status of the person interviewed (entrepreneur, self-employed, salaried worker) and her/his position in the informal economy. IRM and worker/entrepreneur interviewees were contacted through local associations and businesses, as well as the networks of expatriate social

centers such as the Swedish Church. They were also recruited through the 'street approach', walking up to potential participants in different residential areas (including campsites), cafes and meeting spots around town, as well as through advertisements in Swedish contact zones[2].

Rights, Obligations and Provision of Care and Services in IRM Destinations

Due to EU Freedom of Movement rights, Swedish citizens are free to reside in Spain. IRMs may either be seasonal residents in Spain (living up to six months per year in Spain while being registered as permanent residents and taxpayers in Sweden) or registered as permanent residents in Spain (which means paying taxes in Spain and a special 'living abroad' tax in Sweden called SINK). If IRMs are registered as resident in Spain, they have full access to the Spanish social security system (after five years). If IRMs live in Sweden for more than six months per year and/or keep a permanent residence in Sweden (as opposed to a summer house or 'holiday apartment'), they are obligated to pay their taxes in Sweden (which are higher than Spanish ones and may make a difference for those with high incomes). If IRMs are seasonal residents in Spain, they only have rights to emergency care in Spain and they may also apply for planned care in Spain funded by the Swedish social security system (in case the queue is longer in Sweden). Swedish retirees receiving their pension abroad are obligated to submit a certification each year to prove that they are still alive. If they fall ill or pass away in Spain and need transportation back to Sweden, the Swedish consulate does not pay the costs. Both seasonal and permanent IRMs may purchase private insurance for a number of reasons: in order to minimize risk (in case something occurs that would require more than their emergency EU health insurance which every EU citizen has a right to), in order to ensure shorter queues and higher quality care, or in order to have access to clinics where there is Swedish- or English-speaking staff. However, private insurance can be very expensive, especially for those with certain health conditions such as, for example, diabetes. As we will demonstrate in this chapter, for some IRMs, these are precisely the factors that limit mobility.

The majority of IRMs are not registered as permanent residents in Spain, and most return to Sweden when they, or their partner, reach dependency on extensive eldercare. IRMs who have registered as permanent residents in Spain, but are still Swedish citizens, may re-register as permanent Swedish residents when they return to Sweden. Back in Sweden, they may have access to a relatively high (but shrinking) public provision of eldercare carried out in their native language, as well as possibly unpaid care by family members. However, those IRMs who try to extend their stay in Spain, seasonal as well as permanent, end up with a number of mostly private options, and access to full coverage of extensive care needs is unaffordable to the majority. For reasons we will explain below, it is extremely rare for IRMs to rely on public Spanish eldercare provision, even among those who are registered as permanent residents in Spain. Most IRMs in Spain turn to a combination of informal and formal care provision: unpaid family care (by partners, children and grandchildren); IRM friends/organizations/churches/volunteers; and paid care services provided by self-employed Spanish or migrant women (mostly Swedish or South American).

At the time of writing, two parallel systems of public care for the elderly coexist in Spain. On the one hand, the old fragmented system of assistance organized by municipalities, means tested, and oriented only to the worst-case scenarios (lone persons with severe dependency situations and very low incomes). Few Swedish IRMs, who are registered as permanent residents in Spain, fall into these extreme situations, and hence it is by no means a solution for the needs of the majority. On the other hand, we are witnessing the development of the new 'Dependency Law', of universal nature, but it is still in the process of implementation. When fully applied, the 'Dependency Law' will provide public support for all levels of dependency, but right now, it is only covering severe cases, which excludes the situation of most IRMs. In addition, benefits are universal but subject to co-payment according to the user's income. For middle-income IRMs, the amount of the co-payment through the formal market can be more expensive than the full cost of hiring an informal worker and the higher cost of formal services may restrain many permanently resident IRMs to apply for public help in Spain even if they are eligible.

The decision process, mobility options and strategies of IRMs may unfold gradually over time. As they grow older, retirees may feel slightly less

autonomous but not even near to the point of having to consider moving back to Sweden, moving to an elderly home, or contracting a professional caregiver. Thus, firstly many IRMs choose to hire a cleaner some hours per week, or only for heavy tasks such as cleaning the windows. As time goes by, other needs may arise. Physical mobility can start being a problem for some IRMs, for instance, the long flights for those living in the Canary Islands, or living in urbanizations located far from commercial centers, supermarkets and cafes. To carry groceries or visit the doctor can become more problematic than before. At this point, most Swedish IRMs exercise their exit mobility and decide to move back to Sweden permanently.

For instance, a female IRM interviewee rents an apartment in Milanillos on Isla Bonita[3] in the Canary Islands and is registered in Sweden, where she also has an apartment and plans to return eventually. She says she will continue going as long as she is healthy enough to make the flight and go grocery shopping, and she is in a queue for elderly housing in Sweden. She has heard that it is too complicated to try to stay on Isla Bonita in older age: that one needs to pay for everything privately and that there is no security and provision of home-based services for elderly here that could compare to Sweden.

For another example, we interviewed an IRM couple in their 90s on Isla Bonita who had bought an apartment near the 'Swedish hub' on the island, the town where most Swedish infrastructure is located, such as the clubs, churches, shops and restaurants. They used to be registered as permanent residents in Spain but are now seasonal residents re-registered in Sweden. They also have a house in Sweden but are planning to sell this house in order to move into 'lifestyle senior housing'. The couple intends to sell their apartment on Isla Bonita and instead rent an apartment on a monthly basis for shorter visits. Aging is making it more difficult for them to manage the long flight.

Eventually, for reasons of health, access to elderly care, language problems (which may worsen in case of dementia or Alzheimer's) or being closer to family (especially adult children and grandchildren), most IRMs return permanently to Sweden either deliberately or against their will. As one entrepreneur on Isla del Sol in the Canaries said: 'what is the use of being in the world's best climate if one is ill and constrained to one room all the time?' He claims that almost all IRMs have an internal clock that drives them to move back 'home' to the familiarity of their native language and kin when they reach dependency.

Informal and Formal Provision and Strategies for Care and Domestic Services

Among our IRM interviewees on Costa del Sol, the superior Spanish health care system was frequently mentioned as a reason to move to Spain, in contrast to our interviewees on the Canary Islands. Andalucía and the Canary Islands are two different regions, with different economic structures, political traditions and organization of social and health care services that may impact the lives of IRMs[4]. However, in contrast to health care, no IRM interviewees considered Spanish public eldercare preferable to the Swedish alternative, regardless of which region they resided in. In addition, due to a combination of underfunding and social norms concerning the role of the family, Spanish public health care expect family members to carry out certain care-related tasks within hospital premises. In other words, IRMs may need to hire extra private services, such as interpreters and private carers to visit hospitals and health clinics. As we explained above, the scarcity and fragmentation of Spanish public long-term care programs forces IRMs (and Spaniards) to rely on a mix of strategies to cover their care needs in old age. Apart from voluntary help from associations, family and friends, the alternatives are elderly homes, care/domestic service companies and self-employed domestic/care workers.

The most common solution for services among IRMs is to hire Spanish or South American domestic workers informally, at an hourly rate around 10 euro (USD11) or less. This is considered affordable by IRM interviewees with low levels of care needs, and some (especially on the Canary Islands) mention the lower salary levels in Spain and/or the high unemployment in the region as a reason why it is so easy to find cheap domestic services. IRMs find these workers by word of mouth in Scandinavian meeting places (associations, church, restaurants and media), through intermediaries or even by recommendation from Spanish social workers.

IRMs may combine domestic workers (who tend to speak Spanish and possibly English only) with a Swedish-speaking carer (who does not necessarily need to be a Swedish citizen, it could be a Scandinavian citizen, a migrant from a third country or a Spaniard with a main background living in Sweden) whom they hire formally or informally at an hourly rate of 15–20 euro (USD16–22) per hour. There are some formally registered home care/

service companies run by Swedes in IRM areas. In addition, some IRMs live in urbanizations or apartment buildings that provide or intermediate all kinds of services, including cleaning and care. One Swedish home care worker who provided informal elderly care to IRMs in Guadamecer on Costa del Sol for 15–20 euro per hour said that there are IRMs who do not have relatives and she works for them as long as possible; for some, she is their only 'family'. Her clients are mostly women or couples where one needs help taking care of the other. The care needs of IRMs with dementia and Alzheimer's are especially large; some need 24-hour care.

IRMs tend to move to Spain as couples and return to Sweden as singles when one passes away. Having a partner around or not (i.e., having unpaid family care) has a great impact on mobility and options for independent aging. This has gendered implications in heterosexual couples, since women tend to live longer and earn less than men (who are usually older than their wives), and are likely to take on greater care responsibilities. Without access to public provision and unpaid family/social network provision, the eldercare puzzle shifts to privately paid market solutions. A 90-year-old widower on Costa del Sol hires a Spanish domestic worker informally who cooks and cleans and takes care of him. She charges 10 euro per hour. Another IRM widower on Costa del Sol says there is no elderly care available, so if he falls ill he has to rely on getting his children to come over from Sweden or pay someone privately in Spain to take care of him. He can also ask IRM friends to help out if things get bad (*om det kniper*). This interviewee had private insurance before, but it became too expensive because of his diabetes: private insurance is only for the very wealthy, he says. Another widower on Costa del Sol said his (now deceased) wife lived at an elderly care home in Spain during her last six to eight years and it worked fine. It cost 2500 euro per month (USD2800), and he considers this solution for himself as well. Now he hires two Spanish women who cook, drive and clean his apartment, which costs him 1000 euro (USD1150) per month for both of them (unclear how many hours they work per month).

Because both formal and informal domestic services are so cheap in Spain compared to Sweden, very few IRMs find it worthwhile to use the Swedish tax reductions called RUT for domestic services even though they have a right to these tax reductions if they are still registered as

residents and taxpayers in Sweden. Using formal tax-reduced services in Spain would still be more expensive than using informal services (as opposed to the associated ROT reductions for the more expensive handyman services, which were more frequently used than the RUT reductions among IRMs in Spain). One Swedish domestic worker/carer we interviewed works for a company that seeks to attract RUT customers. The company charges 35 euro (USD39) per hour, but this becomes only 17.50 per hour after the RUT reduction. However, this is still almost twice as much as the regular prices for informal services and still higher than formal Spanish options (e.g., cleaning services provided by other companies registered in Spain).

One should not overestimate the number and client base of Scandinavian-oriented home service companies. As far as we have seen, they are small companies in an initial phase of development that have difficulties to find a substantial amount of paying customers and to find staff with the required qualifications (knowledge of both Swedish and Spanish languages, preferences and experience in eldercare), and are forced to compete with an informal market characterized by miserly salaries (even as little as 5–8 euro/USD5.50–8.90 per hour). A Swedish entrepreneur who runs a care service business in Guadamecer on Costa del Sol explained that she stopped offering some basic services like cleaning or shopping because she could not compete with the low prices charged informally by Spaniards.

One social worker at a private hospital oriented to Scandinavian clients told us that he suggests several companies and professional caregivers to patients who need home care after surgery. But many elderly Swedes do not want to pay the high prices fixed by Scandinavian-oriented companies/professionals, neither will they accept the low level of qualifications and language limitations of a Spanish informal caregiver, which forces them to eventually return to Sweden. Another social worker, also hired in a private hospital with a majority of Northern European patients, observes that Northern Europeans in general, and Scandinavians in particular, expect a level of care that the Spanish system (public or private) in unable to offer them. Public social workers feel the arrival of IRMs among their clients as an additional burden to be added to the lack of adequate funding and the increasing demands brought about by the

economic crisis. Social workers are by no means hostile to IRMs, and many express a desire to help them as much as they can with the little resources that they have. However, sometimes they feel slightly offended by the exigent attitude and negative comments of Scandinavian IRMs concerning Spanish social services. As the social worker of one of the primary health care centers of the Canary Islands told us:

> Sometimes they say 'in my country things are different', 'in my country things are not like that'. And I feel like telling them 'ok, so go to your country. This is Spain and this is our way of doing things'. Of course I never say that, but sometimes I would like to.

Notwithstanding the small proportion of IRMs among their clients, most social workers perceive dependency among IRMs as a problematic situation for which Spanish social services are totally unprepared. The first problem is the language. The majority of Scandinavian IRMs that require help from the social services do not speak Spanish, and town councils do not have interpreters among their staff nor a special budget to pay for them. Social workers need to ask the person to bring an interpreter or, when this is impossible, to rely on the informal help from the Scandinavian community or the formal (but slower) help of the consulate. The second problem has to do with the lack of integration of Scandinavian IRMs in the Spanish system and society. Social workers are unable to gather information from the family or the primary care doctor if the person has not been registered in Spain and has no family nearby. Third, social workers mention the strong reluctance of Scandinavian elderly to receive help from the social services.[5] In most cases, especially those of more desperate need (isolation combined with low or no income and severe disabilities), it is not the IRM that contacts the social services but a friend, her/his landlord, or the manager of their residence. And finally, all social workers refer to the scarcity of public funds, a problem that affects social services in general, and that makes it impossible to create special programs/help for IRMs.

In Costa del Sol, we found some private eldercare homes especially focused on Northern European or Scandinavian IRMs but, since they are completely privatized with no portable subsidies from Sweden, they are

way too expensive even for those with relatively high pensions. There were Swedish interviewees who called for collaboration between Swedish and Spanish governments for offering state-sponsored elderly care services to Swedes in Spain, and stressed how this would benefit both parties. Private eldercare homes that focus on Spanish clients do offer lower prices than the ones focusing on Northern Europeans, and their managers are more than willing to attract IRMs but, as far as we have seen, their efforts to adapt their services to non-Spaniards have not been met by substantial demand from Scandinavian IRMs. As a response to the arrival of the 'Dependency Law' in 2007, private eldercare homes substantially increased the number of available beds, but the economic crisis in 2008 partly frustrated their expectations of growth. Drastic reductions of public funds slowed the application of the Law and the number of beneficiaries, and the enormous increase in unemployment forced many Spanish families to bring their elder dependents back home. The manager of a large private eldercare home in Tejar del Monte on Costa del Sol explained to us that she has managed to have an occupation of almost 100 % during the crisis, thanks to the Northern European residents, while the manager of another one (run by a religious order in Torremoros on Costa del Sol) hopes to be able to fund the beds for charity patients with the arrival of IRM residents.

Economic, Gendered and Health Differences Among IRMs

Gender is an important component in analyzing the purposes, experiences and work- and care-related outcomes of migration processes, both when it comes to IRMs and to their service providers, especially female-dominated home-based cleaning/care, as well as male-dominated handyman services (Kilkey et al. 2013; Lutz 2008). As we mentioned earlier, Spain has traditionally been a familialistic care regime in which all tasks related to care for dependants (children, disabled, older people) have traditionally been shouldered by women. We can see a gender bias in care among all types of providers for IRMs when it comes to unpaid care as well as paid care by state, market and family. In our interviews, the heads of private eldercare homes, of Spanish companies of care services, and

also of companies oriented to Northern Europeans were women (except in one case). The majority of the staff in these private companies was also women, as well as most self-employed carers.

There are gendered aspects to mobility and independent aging among IRMs which cut across factors like income and health; those IRMs who end up providing paid and unpaid care are usually women. A large proportion of our IRM interviewees retired early, before the age of pension eligibility. Some lived on savings before pension eligibility and others (i.e., women) on their partners' income. It was especially common for women to retire early when their older male partner decided to move to Spain for health or quality of life reasons. One widow IRM interviewee said that she 'sacrificed' herself; her husband was older and ill and wanted to move to Spain before she could retire. IRMs were often aware of the difficult situation for widows and pointed this out. Some IRMs re-partner, some move back to Sweden when their partner passes away, while others try to get by on their own in Spain. Especially widows and single women attribute great importance to adult children and grandchildren and they might decide to move back to Sweden to be closer to them. The few IRMs who had integrated into Spanish society and had Spanish partners or adult children expected their family to take care of them in old age, like Spaniards have been forced to do traditionally, even though they do actually not prefer this solution to public provision (Calzada and Brooks 2013).

Even though widowers also suffered from diminished income and family care, we heard more examples of widows who suffered from socioeconomic deterioration when their (male) partner passed away. In this context, gendered division of work may be a significant factor in eldercare puzzles: for example, in same-sex couples two women typically earn less, and live longer than two men. Women typically had much lower pensions than their husbands and some had stayed at home with multiple children (which gave them even lower pension credits). In social networks consisting of Swedish IRMs, efforts were made to try to include widows in (often couple-based) social activities and to check regularly that they were well. One widow IRM interviewee said: 'one is more vulnerable in a society based on couples.' But IRMs knew all too well that they might end up in the same situation: as widows or widowers who stay on in Spain after their partners pass away.

Thus, the family situations of IRMs profoundly impacted their mobility. But care goes both ways here; not only are older people recipients of care, they are also givers of care to each other or to younger generations of their families. IRM interviewees have different approaches to adult children and grandchildren. Some IRMs considered it a sacrifice to live far away from them, and some planned to move back to Sweden in order to be closer to their grandchildren. Between couples, there was not always an agreement about these priorities and strategies. For instance, in an interview with a couple on Costa del Sol, the wife said that living in Spain meant sacrificing time with children and grandchildren, but the husband commented: 'that's her opinion: if we were in Sweden they would take advantage of us for babysitting.' The wife then replied: 'I wouldn't mind: I miss them terribly.' In contrast, there were IRMs who spoke of freedom *FROM* (having to take care of) grandchildren; living far away from them leaves IRMs time to explore other interests and relationships. There were IRMs who spoke about pressures from children and grandchildren to come home for Christmas but there were also IRMs who spoke of their adult children as being too busy to visit them in Spain. Opportunities to see grandchildren can also be an economic issue: some IRM interviewees had bought, or rented, apartments in Sweden mainly to be able to visit grandchildren.

There were large differences among IRMs in terms of economic conditions for mobility. On the one hand, there are IRMs who moved to Spain with the capability to do so; they have the means for investments and active consumption in Spain and they tend to own double residences in Spain and Sweden. On the other hand, there are IRMs who move to Spain out of economic necessity: they are mainly motivated by the cheaper living costs in Spain and cannot afford to live in Sweden. This aspect is rarely apparent in research on IRM 'lifestyle migration', but among our interviewees, who came from a wide range of socio-economic backgrounds, getting more out of their pension was a significant factor. In other words, some IRMs migrate or live transnationally because they want to; other IRMs because they have few bearable options. Some IRMs even need to work for other IRMs (with cleaning and care) in order to get by, for instance, when circumstances change unexpectedly.

Socio-economic conditions among IRMs are sometimes discussed by interviewees in terms of age cohort. Retirees born in the 1940s (so-called

40talister or baby boomers) are generally considered relatively wealthy, and on average, they also have better pensions than both previous and subsequent cohorts (Blaakilde and Nilsson 2013). In addition, *40talister* are considered more cosmopolitan, more active and more demanding as customers than previous generations of retirees. There were IRM interviewees who were so self-conscious about their position as active consumers (as opposed to passive recipients) of care that they spoke of their decision to move to Spain in terms of an investment in their well-being, of prioritizing quality of life, despite extra costs of living transnationally (like double residence, travel, etc.). For example, one IRM interviewee who had lived seasonally in Valleviejo on Costa del Sol thinks one should invest in well-being at her age: 'I can't afford to be unwell: it's about quality time! Carpe Diem (seize the day)!' These IRMs could afford to solve their eldercare puzzles as they pleased and felt that the complete privatization of their services gave them a greater degree of control and independency. However, most IRMs are neither extremely wealthy nor extremely poor: they make priorities, cut corners if they have to and make ends meet.

Health status is another mobility factor that intersects with socioeconomic resources and access to care among IRMs. Especially on the Canary Islands, there are IRMs who are mainly motivated by health problems to move to Spain: due to disability or illness like rheumatism, multiple sclerosis (MS), or asthma. The warm and stable climate on the Canary Islands significantly improves the well-being of these IRMs, or that of their partner/family member. However, regardless of health status, IRMs in general perceive life in Spain as beneficial to health, especially considering the warmer temperature and longer daylight in Spain compared to Swedish winters, which, as many point out, saves them from ice- and snow-related accidents and enables them to have a physically active life in the outdoors the whole year around. For instance, one interviewee said that with the extra three and a half daylight hours in Spain, you get three and a half hours extra per day of your life. It was not uncommon for IRMs to claim that living in Spain adds another extra ten years to their lifetime. Correspondingly, because many IRMs lived a healthy and active life, including morning walks and recreational activities, they manage very well independently for their age and might not need eldercare until very late in life.

Some IRMs who are not registered as permanent residents in Spain take very high risks without rights to Spanish public health and eldercare, and without private insurance. Despite holding EU citizenship, there are economic limits to the mobility of these IRMs. There are IRMs who are at risk of poverty and stagnation in later life, with extremely low incomes and low exit mobility such that they could not even afford the plane ticket back to Sweden. With no (private) social insurance and no social rights in Spain (beyond emergency care through their EU citizenship), these IRMs fall between the two welfare systems in a state of immobility. We came across IRMs in difficult circumstances: socially isolated IRMs without families, relatives, or friends around; IRMs with dementia or Alzheimer's who lost control over their lives; IRMs with alcohol issues; and IRMs who were poor. These 'worst-case scenarios' could go on without anyone noticing or trying to help, unless social services, churches, consulates, volunteer organizations, or others were alerted and intervened.

Conclusion

Both Spanish and Swedish welfare and care regimes are shifting (the former toward state provision and the latter toward market provision), but in both regimes, informalization and familialization entail increased reliance on unpaid care by women. While healthy and physically active middle- to high-income IRMs exert a high degree of mobility with their transnational lives, low-income IRMs might end up in a state of immobility which worsens as they enter dependency on extensive eldercare. When IRMs attempt to solve their eldercare puzzles, unpaid family care and social networks turn out to be an important piece of the jigsaw in a care and welfare regime like Spain, in order to compensate for the lack of access to publicly funded eldercare. When age-related dependency hits a certain level, marketization through wealth (the ability to pay for private care) provides the only possibility for IRMs to stay in Spain. The majority of IRMs who seek to extend their stay in Spain have to struggle to find care provision combining a mix of strategies as they go along and relying on (and hence reinforcing) an informal market that is detrimental for recipients and providers alike; informal caregivers' positions in the labor

market (low salaries, no social security contribution, low qualifications), especially in the case of migrant women from outside the EU, almost guarantee them poverty in old age (see Gavanas and Calzada 2016). The necessity to rely on unpaid family care while solving elderly care puzzles in Spain has gendered consequences, especially for IRM women, as well as Spanish and migrant women in heterosexual, single and same-sex family constellations, since they tend to live longer and usually have lower incomes than men. However, as compared to Spanish elder people and non-EU migrants in Spain, Swedish citizens do possess the option of exit mobility, to return to the extensive provision of eldercare in Sweden. In Sweden, poor older people have rights to social assistance and housing benefits, but there are still 'worst-case scenario' IRMs trapped in immobility who do not have the capacity, means, health, social network, or family to organize a return. Some IRM interviewees felt they had nothing to return to, neither affordable housing nor a social/family context.

Is Spain becoming Europe's eldercare home? Are IRMs draining the underfunded Spanish welfare state? Spanish social institutions and services functioned as the 'last resort' for a minority of IRMs who had lost control over their lives; when neighbors and acquaintances intervened and brought in social services to IRMs, they were often unwilling to receive such help. Simultaneously, private care actors in Spain approach the IRM phenomenon as a possible strategy to get by in times of economic crisis, when Spaniards resort to unpaid family care.

Twenty-five years ago, Francisco Jurdao and María Sánchez, two Spanish scholars, carried out one of the first large studies on IRM in Spain: *Spain: Asylum of Europe* (1990). The conclusions were worrisome: IRMs lived in recently built areas some kilometers away from the Spanish villages, isolated and with poor services. They did not integrate into Spanish society nor could they communicate with Spaniards, remaining enclosed in their own very small groups. Their massive arrival was partly responsible for the overcrowding and overbuilding of the Spanish coastline, for the inability of public services to cope with all the residents' needs, as well as for the loss of identity of Spanish traditional coastal villages. As a risk for the future, Jurdao and Sánchez pointed out that the lack of integration of IRMs, combined with underfunded social services, could result in difficult situations for those IRMs who stay in Spain until very old, who could find themselves 'trapped' in the Spanish asylum.

The situations that we have seen during our study are not as severe as the ones forecasted by Jurdao and Sánchez, probably due to the fact that part of the problems that they detected 25 years ago have been alleviated over time: services in urbanizations are now better, public health services have improved both for Spaniards and IRMs, and locals do not perceive the arrival of their IRM neighbors as a danger for their culture or way of life as long- and short-term tourism has become normalized in Costa del Sol and the Canary Islands. However, some of the patterns detected by Jurdao and Sánchez are certainly visible: the most attractive coastlines are completely built up and there is no adequate, accessible and affordable provision of care for those elder IRMs who stay in Spain until very late in life. Public eldercare services are underfunded and understaffed; private care companies/eldercare homes are either too expensive or not adapted at all to non-Spaniards; and IRMs with low resources may actually find themselves 'trapped in the Spanish asylum', in a state of immobility with no exit.

Notes

1. Acknowledgments: this article is based on a project funded between 2013 and 2015 by two agencies: the Swedish Research Council (VR) Dnr 421-2012-675 and the Swedish Research Council for Health, Working Life and Welfare (FORTE) FAS Dnr 2012-0223. We are indebted to Virginia Paez and Gunilla Rapp for transcriptions and assistance.
2. In order to preserve anonymity, both samples (IRMs and workers/entrepreneurs) have been contacted independently. That is, workers were contacted neither through IRMs nor through the opposite.
3. For anonymity reasons, all names of locations are pseudonyms.
4. Andalucia has had socialist governments (Partido Socialista Obrero Español) since the start of democracy in Spain, while the Canary Islands has had different parties in power, and since 1993 is ruled by a center-right regionalist party (Coalición Canaria). Political differences are reflected in the funding and functioning of public and social services, mostly in the NHS. The Canary Islands is the region where citizens' satisfaction with the performance of public health services is lowest.
5. Social worker interviewees consider that IRMs' reluctance to use Spanish social services is grounded on the one hand on Swedish cultural norms that stress independent living, and on the other hand, on a preference to be cared for in their own language and by their own community.

References

Anttonen, A., & Sipilä, J. (1996). European social care services: Is it possible to identify models? *Journal of European Social Policy, 6*, 87–100.

Attias-Donfut, C., Ogg, J., & Wolff, F. C. (2005). European patterns of intergenerational financial and time transfers. *European Journal of Ageing, 2*, 161–173.

Attias-Donfut, C., Ogg, J., & Wolff, F. C. (2008). Evolution of social support. In A. Börsch-Supan (Coord.), *First results from the survey of health, ageing and retirement in Europe (2004–2007): Starting the longitudinal dimension*. Mannheim: Mannheim Research Institute for the Economics of Aging.

Bauman, Z. (1998). *Globalization. The human consequences*. Cambridge: Polity Press.

Bernard, H. R. (2006). *Research methods in cultural anthropology* (4th ed.). Lanham: Rowman Alta Mira.

Blaakilde, A. L. (2013). The challenge to the Danish welfare-state: How international retirement migration and transnational health-promotion clash with national policies. In A. L. Blaakilde & G. Nilsson (Eds.), *Nordic seniors on the move: Mobility and migration in later life*. Lund: Lund Studies in Arts and Cultural Sciences.

Blaakilde, A. L., & Nilsson, G. (Eds.). (2013). *Nordic seniors on the move: Mobility and migration in later life*. Lund: Lund Studies in Arts and Cultural Sciences.

Brandt, M., Haberkern, K., & Szydlik, M. (2009). Intergenerational help and care in Europe. *European Sociological Review, 25*, 585–601.

Brodin, H. (2005). *Does anybody care? Public and private responsibilities in Swedish eldercare 1940–2000.* PhD Thesis, Umeå University.

Calzada, I., & Brooks, C. (2013). The myth of Mediterranean familism. *European Societies, 15*, 514–534.

Esping-Andersen, G. (1999). *Social foundations of post-industrial economies*. Oxford: Oxford University Press.

Gavanas, A. (2013a). Elderly care puzzles in Stockholm; strategies on formal and informal markets. *Nordic Journal of Migration Studies, 3*, 63–71.

Gavanas, A. (2013b). Svart och vitt i äldres omsorgspussel. Hushållstjänster och privatisering av äldreomsorgen i Stockholm. In A. Gavanas & C. Calleman (Eds.), *Rena hem på smutsiga villkor? Hushållstjänster, migration och globalisering*. Makadam: Göteborg and Stockholm.

Gavanas, A., & Calzada, I. (2016). Multiplex migration and axes of precarization: Swedish retirement migrants to Spain and their service providers. *Critical Sociology* (forthcoming). doi:10.1177/0896920516628306

Gavanas, A., & Mattsson, A. D. (2011). *Bland Rolexklockor och smutsiga trosor. Om skattereduktioner och segmentering på den svenska hushållstjänstemarknaden. Arbetsrapport 2011: 9*. Stockholm: Institutet för Framtidsstudier.

Hedlund, E. (2011). *Utvandrare.nu: från emigrant till global svensk*. Stockholm: Föreningen svenskar i världen.

Huete, R., & Mantecón, A. (2013). La migración residencial de noreuropeos en España. *Convergencia Revista de Ciencias Sociales, 20*, 219–245.

Jurdao, F., & Sánchez, M. (1990). *España: Asilo de Europa [Spain: Asylum of Europe]*. Barcelona: Planeta.

Kilkey, M., Perrons, D., Plomien, A., Hondagneu-Sotelo, P., & Ramirez, H. (2013). *Gender, migration and domestic work. Masculinities, male labour and fathering in the UK and USA*. Basingstoke: Palgrave Macmillan.

Kohli, M., Künemund, H., & Vogel, C. (2008). Shrinking families? Marital status, childlessness and intergenerational relationships. In A. Börsch-Supan (Ed.), *First results from the survey of health, ageing and retirement in Europe (2004–2007). Starting the longitudinal dimension*. Mannheim: Mannheim Research Institute for the Economics of Aging.

Korpi, W., & Palme, J. (1998). The paradox of redistribution and strategies of equality: Welfare state institutions, inequality and poverty in the Western countries. *American Sociological Review, 63*, 661–687.

Lister, R., Williams, F., Anttonen, A., Bussemaker, J., Gerhard, U., Heinen, J., et al. (2007). *Gendering citizenship in Western Europe: New challenges for citizenship research in a cross-national context*. Bristol: Policy Press.

Lutz, H. (Ed.). (2008). *Migration and domestic work: A European perspective on a global theme*. Surrey: Ashgate.

Meagher, G., & Szebehely, M. (2010). *Private financing of eldercare in Sweden: Arguments for and against* (Working Paper 1/2010). Stockholm: Institute for Futures Studies.

Meagher, G., & Szebehely, M. (2013). Long-term care in Sweden: Trends, actors and consequences. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe. Investigating institutional change and social impacts*. New York: Springer.

Nilsson, G. (2013). Breaking free and settling down: Contradictory cultural meanings of rural retirement migration among Swedish seniors. In A. L. Blaakilde & G. Nilsson (Eds.), *Nordic seniors on the move. Mobility and migration in later life*. Lund: Lund University.

Österle, A., Bauer, G., & Haidinger, B. (2011, April 14–15). *Migrant care work and care regimes in the European Union*. Paper presented at making connections: Migration, gender and care labour in transnational context, COMPAS, Oxford.

Simonazzi, A. (2009). Care regimes and national employment models. *Cambridge Journal of Economics, 33*, 211–232.

Szebehely, M. (2004). Nya trender, gamla traditioner. Svenskäldreomsorg i europeiskt perspektiv. In C. Florin & C. Bergqvist (Eds.), *Framtiden i samtiden - könsrelationer i förändring i Sverige och omvärlden*. Stockholm: Institutet för Framtidsstudier.

Szebehely, M. (2011). Insatser för äldre och funktionshindrade i privatregi. In L. Hartman et al. (Eds.), *Konkurrensenskonsekvenser. Vad händer med svensk välfärd?* Stockholm: SNS förlag.

Ulmanen, P. (2013). Working daughters: A blind spot in Swedish eldercare policy. *Social Politics, 20*, 65–87.

Urry, J. (2007). *Mobilities*. Cambridge: Polity.

Williams, F., & Gavanas, A. (2008). The intersection of child care regimes and migration regimes: A three-country study. In H. Lutz (Ed.), *Migration and domestic work: A European perspective on a global theme*. London: Routledge.