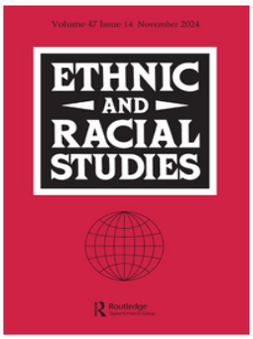

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Care and wellbeing across Europe – a research frame for studying migrant families

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ABSTRACT

All over Europe, the question of sustainable care for the older people gains attention. Although the number of older migrants is increasing significantly, to date only little empirical research deals with migrant family care. In this paper, we thus give an overview of theoretical models on care and wellbeing and adjust them to (different groups of) migrants across Europe. We then present (rare) empirical studies on (in-) formal care and wellbeing, asking: do migrants give/use care more likely than natives and if so, why? Are migrant caregivers more or less burdened compared to non-migrant caregivers? How did the pandemic affect migrant caregivers? Based on our assessments of the state of quantitative research we highlight limitations and propose paths for future research on care in migrant families.

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KEYWORDS Ageing; caregiving; COVID-19; health; migration; social inequality

Introduction

In ageing societies and exacerbated by recent crises such as the COVID-19 pandemic, the question of sustainable care for older people gains more and more attention. On an individual level, health declines in older age are related to a higher risk to become care dependent (Brandt, Kaschowitz, and Lazarevic 2016; Hajek and König 2016). However, the individual risk of needing care in older age depends on social dimensions like education, income and working life history (Schmitz 2019; Schnitzer et al. 2020). The same applies to caregiving, i.e. to support elderly friends or family members with day-to-day help and hands-on care: women and individuals with lower socio-economic status (SES) are more likely to give (intense) care (Quashie et al. 2022).

Previous research shows that caregivers – especially those who give care to their partners in the household – face higher risks of lower physical and

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psychological health and reduced wellbeing (Kaschowitz and Brandt 2017; Wagner and Brandt 2018). To date, research shows no differences in well-being decline due to caregiving with respect to individual SES or migration status. However, lower SES individuals and migrants do have lower health on average – which makes it important to consider and evaluate potential differences in mechanisms and further long-term health outcomes (Brandt, Kaschowitz, and Quashie 2022; Kaschowitz 2020). Especially during the recent pandemic, wellbeing declines were frequent amongst family caregivers (e.g. Ehrlich et al. 2022).

There are, however, only very few studies on different groups of migrants (not) giving care to their family members or friends and potential health and wellbeing outcomes, and almost none related to COVID-19 (to date) in the European context, as will be shown below. This is surprising, as the number of older migrants increased considerably over the last years and diversity-sensitive care for older people is highly topical in most European ageing societies (Ciobanu, Fokkema, and Nedelcu 2017; Ruspini 2010; Sand and Gruber 2018; Warnes and Williams 2006), and relevant not only for the care users. Therefore, the focus here is on migrants who are "growing old abroad" and have family around. Moreover, the only dimension in which migrants frequently score higher than the autochthonous population is the number of strong network ties; migrants on average have more tight-knit support networks and report more close contacts they can rely on, at least in Germany (Schopf and Naegele 2005).

Mechanisms of caregiving and the relationship to health described in earlier studies (e.g. Kaschowitz and Brandt 2017) are thus even likely more pertinent for migrants with on average poorer health and lower SES, and differing norms and values concerning family support. Further, it is especially interesting to shed light on migrant caregivers in different countries from a comparative perspective, to assess potential contextual influences, such as for example differences in labour market participation of migrants (Kaschowitz 2020). The European context presents a significant variation in migration and socio-political regimes ("real world laboratory") which can be used to assess potential interventions on the macro level.

In this article, we provide a backdrop for all three lines of this special issue, and especially aim at multiple inequalities in the framework of migrant care arrangements (see Amelina, Barglowski, and Bilecen 2024). Our paper is to the best of our knowledge the first to shed light on different care theories, combining and re-focusing them to explain care and its effects on wellbeing of migrant family caregivers, not only, but especially during the recent pandemic, and providing condensed quantitative empirical evidence from Europe based on a systematic literature search ("scoping review"). The focus is on quantitative research that allows us to provide an overview of (a) migrant care patterns in Europe and (b) their potential health

consequences during current turbulent times and (c) derive paths which merit further research.

We start with an introduction into different basic and migrant-specific theoretical approaches and combine them to explain caregiving and care use by migrants before presenting related empirical findings from the rare studies on migrant populations (section Caregiving and care used by migrants across Europe). We then shed light on the theoretical pathways from caregiving to wellbeing, again adjusting them to the (differential) group of migrants and presenting empirical studies addressing such questions (section Wellbeing of migrant caregivers across Europe). Based on such general assessments we ask whether the pandemic might have hit migrant caregivers differently than non-migrant caregivers, indicating the dire need for (quantitative data and) research on and in such societal crises (section Care and wellbeing in pandemic times). In Limitations and paths for future research section, we discuss whether and what kind of limitations in theoretical models on caregiving and wellbeing within migrant families exist and which problems arise from data used to study migrant caregivers. We conclude our article with open questions in order to stimulate further research (infrastructure) developments.

Caregiving and care used by migrants across Europe

Theoretical approaches

In the literature, several models focus on the probability for giving (informal) care and for (not) using professional (formal) long-term care (LTC) services. Broese van Groenou and De Boer (2016) proposed an informal care model (ICM) to explain why individuals (do not) give care to their relatives (Figure 1). Main factors in the model are the disposition of the caregiver, including for example norms of solidarity, spatial proximity, money or competence. Further, the context in the form of the family and social network as well as the availability of community care and technology affect the carers' disposition and the decision to take over informal care. The whole process of informal caregiving is embedded in a specific labour market context, LTC policies as well as socio-cultural norms. The ICM as such does not explicitly answer whether migrants have a higher or lower likelihood of caregiving. However, bringing together the mechanisms in the model, differential selection into caregiving could be relevant if migrants systematically differ from non-migrants in the decisive dispositions (e.g. they could have more positive attitudes towards caregiving and share high caregiving norms with and for family members) and context (e.g. they could have more potential caregivers in their social network to share tasks with). Then again, potential heterogeneity within the group of migrants likely

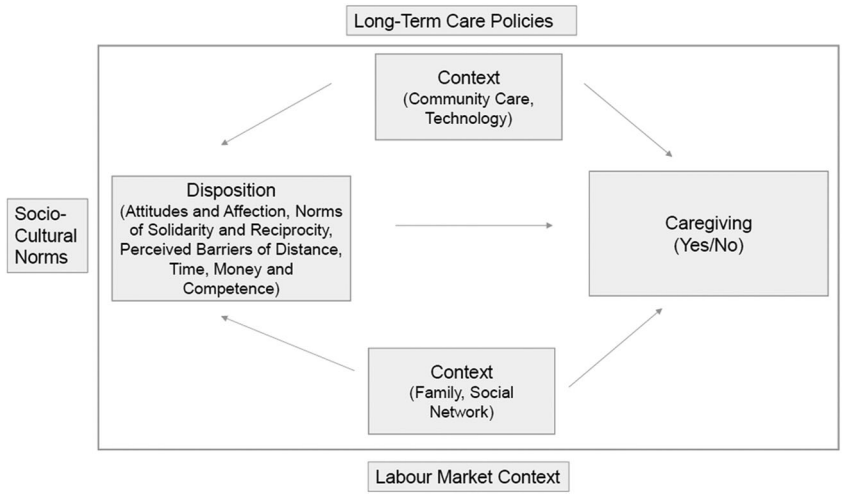

Figure 1. A general model to explain informal caregiving. *Note:* Own graph, based on Broese van Groenou and De Boer (2016).

leads to very different caregiving behaviour for different groups of migrants within one socio-political context.

Further elaborating on contextual influences, Willis (2012) relates actual caregiving and explanations for caregiving to the concepts of individualism, collectivism and ethnic background (Figure 2). Collectivism as cultural values in which family responsibilities rank higher than the needs of an individual family member would lead to more closeness and in turn to a higher chance of caregiving. Other than that, the cultural values of individualism

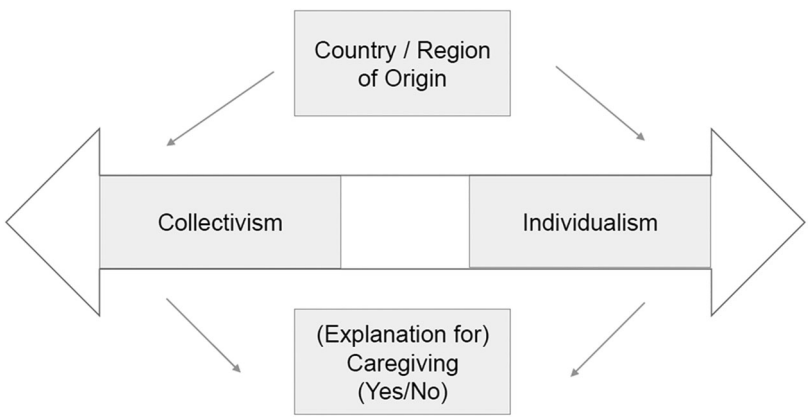

Figure 2. A model to explain caregiving by migrants. Note: Own graph, based on Willis (2012).

are related to more autonomy and lower interdependencies and thus result in a lower chance of family caregiving. This dichotomy can be linked to the country or region of origin. In the case of Europe, more modern and thus individualistic regions would be Northern and Western Europe whereas Eastern, Central and Southern European countries could be considered as more traditional and thus more collectivistic. In a more global perspective, the distinction between modern and traditional would run along the lines of the developed vs. developing world. However, Willis (2012) points out that within countries and their specific migration history, a broad variation of ethnic and cultural diversity exists which in turn leads to different patterns of collectivistic and familial cultural norms among migrants. As this model is based on studies investigating the collectivistic/individualistic scheme in actual caregiving behaviour, it could also be an ex-post explanation rather than a predictor for caregiving patterns (Dilworth-Anderson, Williams, and Gibson 2002; Willis 2012).

Albertini and Semprebon (2020) argue in a similar direction and discuss the role of filial obligations for caregiving by migrants to their elderly parents. They focus on people with Arab backgrounds in the Netherlands and argue that this cultural group is characterized by several principles, which affect support between generations: paternal lineage, patriarchal bargain, patrilocal residence and kin endogamy. But then again, there are within-group differences, as for those Arabs with lower education or stemming from rural regions some principles rank higher. Further, the country of origin plays a role in caregiving behaviour as in Morocco, Tunisia and Algeria, for example, no public support is available and intergenerational co-residence is crucial to be able to meet the needs of impaired older people. However, these patterns might change with growing distance to the origin and across generations just like religious beliefs might.

Other authors look at migrant care from a different angle and focus on the use of LTC, which might complement or even completely outsource informal caregiving. Overall, migrants across Europe seem to use formal care less often and informal care more often compared to the native population (Albertsson et al. 2004; Hansen 2014). This could be either due to barriers (language problems, less knowledge, mistrust, discrimination, poor financial situation) for accessing the LTC system or it could be an active choice in favour of care by relatives (Diederich, König, and Brettschneider 2022; Tezcan-Güntekin and Razum 2017). Based on such arguments, Hansen (2014) proposes a model to explain the use of LTC by migrants taking different barriers into account. LTC use is the result of predisposing factors (e.g. gender, age, education and ethnicity), enabling factors (e.g. income and informal care options) and need factors (e.g. health indicators) but also depends on the care system and the environment (Figure 3).

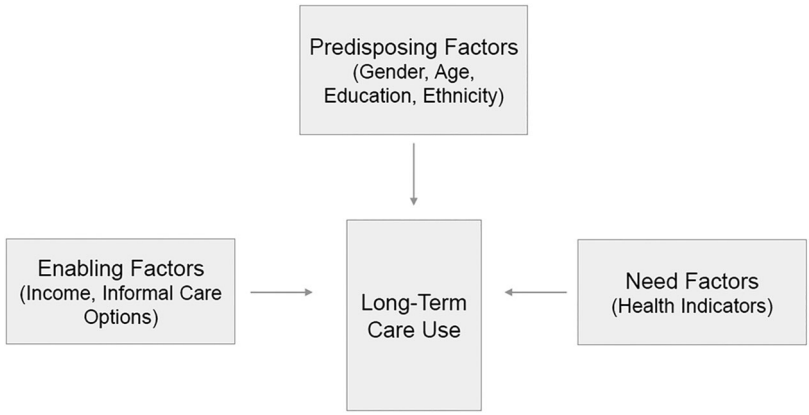

Figure 3. A model for care use. Note: Own graph, based on Hansen (2014).

What we learn from all these models is that migrants and non-migrants systematically differ in certain characteristics, which are important determinants for informal caregiving and (in-) formal care use. This might explain different caregiving patterns that can be observed. However, all theories and models proposed acknowledge profound within-group differences for migrants stemming from different countries/regions or with different SES, interacting with the macro context in the country of residence. Finally, caregiving norms and behaviours might change over family and migration generations, which in turn would lead to smaller or no differences in caregiving and care use within migrant families.

Methodological approach and scope

To collect quantitative studies on migrant care and health and wellbeing we performed a scoping review using the keywords "informal care"/"informal caregiving", "wellbeing"/"health", and "migrant" in a Google Scholar-based research. Only quantitative studies based on survey data which were conducted in Europe (and Israel, due to its inclusion in the comparative Survey of Health, Ageing and Retirement (SHARE)) were considered for this paper as we rather wanted to detect differences across larger groups than give in-depth explanations. The focus on Europe was chosen because of its nature as a "real world laboratory" (similarities and differences in migration histories and care contexts) where caregiving by (certain) migrants in one country can have other effects than caregiving by (certain) migrants in another country.[1] Our review revealed a small but growing body of quantitative empirical studies which address how migrants and non-migrants across Europe differ in their use of formal and informal care and how differences in informal caregiving can be explained.

Empirical evidence

In most of the studies, first-generation or second-generation migrants were investigated, that is either individuals who were not born in the respective country or individuals where at least one parent was born abroad. These migrants mostly have a family around them as they lived in the respective European country for several years and often have children or even grandchildren, as well as older parents. Bordone and de Valk (2016) looked at intergenerational upward and downward support (including practical help, personal care and help with household chores from outside the own household) among migrant families (parent–child dyad) across Europe based on SHARE. In this study of the population 50+, migrants were defined as individuals who were not born in the current country of residence. The authors showed that across countries, the support frequency in migrant families was higher compared to non-migrant families. Such higher support frequency likely also goes hand in hand with a higher probability to give and receive hands-on informal care within the same household. Further, the results revealed that support frequency did not differ between different migrant groups within a country.

For the Netherlands, Merz and colleagues (2009) addressed differences in intergenerational family solidarity by using an 11-item index, including e.g. norms to care for elderly parents by migration generation (first-generation migrants not born in the Netherlands and second-generation migrants whose parents were not born in the Netherlands) and different migrant groups based on their own survey data from The Netherlands Kinship Panel Study (NKPS). The authors investigated four groups of migrants: Turkish, Moroccans, Surinamese and Antilleans and showed differences by country of origin in terms of intergenerational solidarity. Further, religious denominations explained higher intergenerational family solidarity with first-generation migrants and especially among Muslims. However, second-generation migrants did not value family solidarity as high as first-generation migrants did. Moreover, within this group, differences in family solidarity existed by country of origin of their migrated parents. Migrants with Moroccan and Turkish backgrounds scored higher on intergenerational family solidarity values than migrants stemming from the Republic of Suriname and the Antilles. With caregiving to older people being an integral part of intergenerational support by adult children, these differences are likely related to differences in informal caregiving between these groups.

Diederich, König, and Brettschneider (2022) reported different studies showing that migrants in Sweden, Denmark or Germany were more likely to receive informal care but less likely to receive formal care compared to the respective non-migrant population. Against this background, they argued that care behaviour, the use of formal or informal care, might

change between generations but still differs between second-generation migrants depending on their culture of origin with weaker or stronger family ties. Based on the Germany Family Panel (pairfam), they investigated second-generation migrants (respondents who were born in Germany and who had at least one foreign-born parent). Care norms were measured by two items, i.e. "children should accommodate their parents if they cannot take care for themselves any longer" and "children should arrange their work so as to be able to care for their sick parents". Their results showed that second-generation migrants still value informal care more highly compared to respondents with no migration history in Germany. Strong family ties in the parental country of origin explained the more positive assessment of informal care.

For Germany, Tezcan-Güntekin and Razum (2017) pointed out that Germans and older migrants do not differ strongly in their (joint) preference for informal care. All groups would like to grow old in their own home and not in a nursing home. They did, however, not assess possible differences between different migrant groups.

Wilkens and colleagues (2022) used SHARE data for Germany to examine the likelihood of formal or informal care receipt when impairments in (instrumental) activities of daily living ((I)ADL) were reported and if this association was moderated by migration status. Migrants were defined as respondents who were not born in Germany or who were born in Germany with at least one parent born abroad. Formal care was measured by the question whether respondents had received professional or paid services at home in the last twelve months due to a physical, mental, emotional or cognitive issue. Informal care was defined as help from someone inside or from someone outside the household with mainly personal care. The authors argue that migrants with impairments would be less likely to use formal than informal care mainly due to larger families, closer family ties and geographical proximity. Further, the lack of knowledge about the care system could explain less formal care use. Interestingly, impairments lead to higher care use, but migration status did not moderate this association. So, taken together, controlling for different needs and opportunities, migrants did not exhibit higher chances to use informal care than their native counterparts. This again points into the direction that mechanisms of caregiving and care use do not differ substantially, but the available resources and life situations (e.g. income, education and health) differ significantly between migrants and non-migrants.

For Denmark, Hansen (2014) examined if differences in the use of LTC – older migrants less often use home help compared to other Danes – could be related to the length of residence in Denmark and country of origin. The analysis distinguished between migrants from Western countries (mainly Norway, Sweden, Germany, Poland and Great Britain) and migrants

from non-Western countries (mainly the former republic of Yugoslavia, Turkey, Pakistan, Iraq, Iran and Morocco). LTC types under study were residential care, personal care, assistance with domestic chores and home care. Based on administrative data of the Municipality of Copenhagen results suggest that migrants from non-Western countries were less likely to receive assistance with domestic tasks than native Danes. Within the group of migrants, individuals from non-Western countries are less likely used municipal help than migrants from Western countries.

All in all, the empirical results on care by migrants across Europe mainly focus on the perspective of care use. Taken together, most results suggest that migrants are less likely to use formal care and more likely to use informal care. Further, within the group of migrants, differences in caregiving and care use exist. The results show too, that across migration generations, changes in caregiving and care use can arise – however, mechanisms behind (e.g. age versus cohort effects in changing attitudes) could only be detected by longitudinal data. Based on the state of research, we can conclude that migrants are more likely to be informal carers for their relatives, even though they might not systematically differ in their motivations to do so. Since caregiving can be detrimental for health and wellbeing under certain circumstances, which are likely linked to migrant status, it is important to find out more about wellbeing outcomes especially for migrant caregivers.

Wellbeing of migrant caregivers across Europe

Theoretical approaches

The relationship between caregiving and the health of caregivers can be described using the "caregiver stress process model" (Pearlin et al. 1990) which states that the same care situation can be experienced differently and thus lead to different health outcomes because caregivers differ in their SES (income, education), coping behaviour and their (use of) social and formal support (Figure 4).

Given that this model initially was not designed to address migrant caregivers, Knight and Sayegh (2010) developed a related "sociocultural stress and coping model" (Figure 5). This extension assumes that cultural differences relate to different norms and values regarding care which then influence social support (how much care is given to whom) and coping strategies (how do individuals deal with care-related stress). Both can lead to different health outcomes of care within different groups of migrants. Considering these theoretical approaches, migrant caregivers would experience care differently than non-migrant carers. However, it is not obvious whether migrants are more or less burdened by care than the native-born.

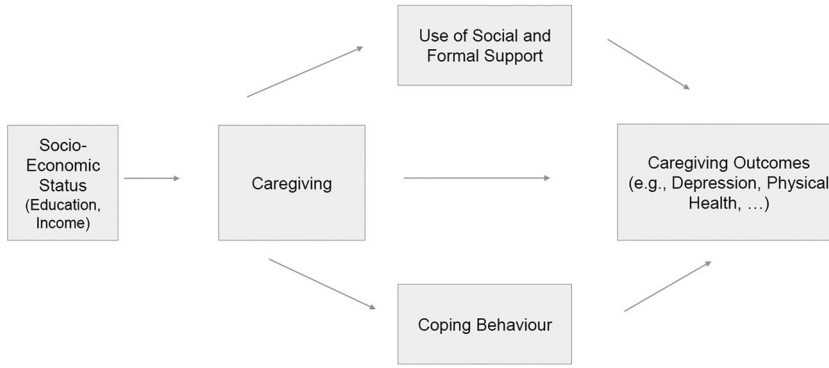

Figure 4. A model for health outcomes of caregiving. Note: Own graph, based on Pearlin et al. (1990).

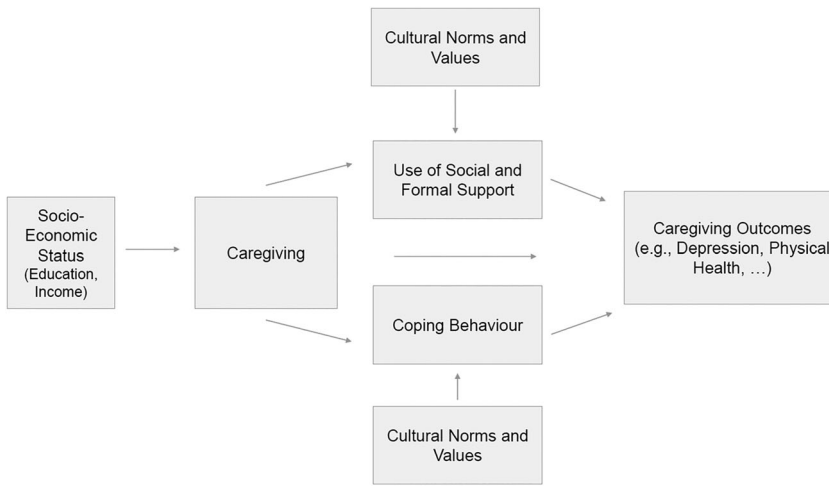

Figure 5. A model for health outcomes of caregiving by migrants. Note: Own graph, based on Knight and Sayegh (2010).

Empirical evidence on wellbeing outcomes of caregiving by migrants

Some but not many quantitative empirical studies address wellbeing changes – including changes in physical or psychological health – due to migrant caregiving across Europe.[2] Soskolne, Halevy-Levin, and Cohen (2007) studied differences in psychological distress between migrants and non-migrant caregivers – adults giving care to their parents/in-laws or spouses – in Israel based on an own cross-sectional survey. To study potential differences, they focused on one of the most important migrant groups in Israel, namely migrants from the Former Soviet Union (FUS). Adult children with migration

history more often gave care to older parents than non-migrants. However, no differences in caregiving distress between migrants and non-migrant caregivers were found once caregiving stressors, resources and caregiving appraisal were considered.

In her 2020 study, Kaschowitz investigated if migrant carers experienced a deterioration in their (self-perceived) health and depressive symptoms as was shown for non-migrant carers based on longitudinal comparative data from SHARE. Migrants were defined as individuals not born in the country of residence. The results prevailed that migrant and non-migrant caregivers, i.e. individuals who gave hands-on-care to a partner or spouse in the same household, slightly differed in terms of socio-demographic characteristics: migrant caregivers were on average younger, more often female, higher educated, more often employed, lived in larger households and more often together with their partner, and had lower income than non-migrant caregivers. In terms of health declines, migrant and non-migrant carers did not differ with respect to mental health. In a country comparative view, migrants experienced the largest negative health effects in Southern and Northern welfare states. However, different groups of migrants within countries could not be separately assessed due to data restrictions.

A more recent study addressed physical health outcomes of care for Ethnic German Immigrants (EGI) compared to non-migrants based on longitudinal German data of the Socio-Economic Panel (GSOEP 2002-2018; Georges 2022). EGI are individuals who are of German descent but mostly lived in Russia or other Eastern European countries and "returned" to Germany after World War II. Compared to other migrant groups in Germany, they can acquire German citizenship more easily as their ancestors were German. EGI are one of the largest groups of migrants in Germany and resemble the autochthonous population in their age structure, their educational level and their cultural norms and values. Caregiving within a household was recorded if at least one interviewee mentioned being in need of care and/or a person mentioned that s/he provided care for at least two hours a week. Physical health was measured using the Physical Component Summary (PCS), which subsumes items on general health, on physical pain, physical limitations, and physical health problems. The results showed a decline in physical health for all caregivers. However, the health declines were remarkably stronger for EGI compared to their non-migrant counterparts.

Although there are not many studies on differences in wellbeing outcomes of caregiving by migrants, most of them showed that migrants firstly have a higher chance of caregiving and secondly start caregiving in initially lower health. However, studies showed no differences in wellbeing outcomes by caregiving between migrant and non-migrant caregivers. We can conclude,

as for caregiving itself that mechanisms leading to wellbeing decline by caregiving do not differ by migration status. However, one has to be careful in interpreting the findings as the sample sizes of migrants in the studies are small or studies cannot account for differential selection into caregiving as they are designed cross-sectionally (e.g. compare groups at one point in time).

Care and wellbeing in pandemic times

The COVID-19 pandemic brought about specific risks for some ("vulnerable") population groups. Amongst them were informal caregivers for older adults who were at risk of increased strain during the pandemic, mainly because support by social networks might have decreased and professional care services were less likely available (Schmitz et al. 2022, also see Kloc-Nowak & Ryan in this special issue). An empirical quantitative study by Brandt and colleagues (2021) focussed on changes in wellbeing and support during the COVID-19 pandemic. Results based on their pilot study revealed that individuals indeed experienced a decline in their wellbeing at the beginning of the pandemic. This was especially true for women and persons of higher age. When it comes to support, the results show that older people withdrew from support for others and women reported difficulties in caregiving to their older relatives.

Another important result is that such reported difficulties in caregiving were related to lower wellbeing (Brandt et al. 2021). Klaus and Ehrlich (2021) and Ehrlich and colleagues (2022) investigated the wellbeing of individuals giving support to others based on a larger sample, the German Ageing Survey (DEAS) during the (informal) "care crisis" (also see Näre & Widding Isaksen in this special issue). Their results show that caregivers reported lower health and wellbeing than before the pandemic. Further, caregivers reported that they missed support by professional services and family to share the increased care burden. However, not much can be said about the specific situation of migrant caregivers – giving care to their relatives and friends – and whether caregiving strain especially increased for this specific group of caregivers.

Different mechanisms for increased caregiving burden by migrants are plausible but can only be addressed theoretically. The theoretical models introduced above suggest differences between migrant and non-migrant caregivers with respect to the use of formal and social support as well as differences with respect to coping strategies which in turn could relate to wellbeing differences (Knight and Sayegh 2010). We argue that some dimensions of caregiving processes and health outcomes were specifically affected by the pandemic (Figure 6). On the individual and network level, the availability of formal and informal social support and coping behaviours were

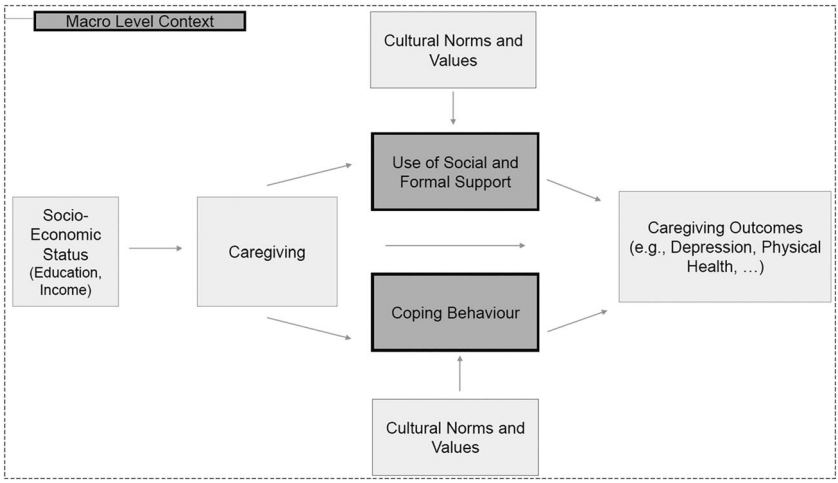

Figure 6. Caregiving during the pandemic. Note: Own graph suggests that the pandemic affected the dark marked areas in particular, based on Knight and Sayegh (2010).

influenced by the pandemic and related mitigation measures. Such measures, again, differed substantially by macro-level context.

If migrant caregivers across Europe rely less on formal care services than on informal support, the closing of day-care and night-care centres during the pandemic (Eggert et al. 2020; Schmitz et al. 2022) would have affected them less and would have not led to changes in their care organization. From this perspective, caregiving strain would at least not have especially increased for migrant family caregivers during the pandemic and one would not expect more severe health outcomes compared to before. However, measures to contain the spread of the virus also included (partly considerable) general contact restrictions in most countries, which likely lead to reduced access to informal support from social contacts (Schmitz et al. 2022, also see Willers in this special issue) – also for migrant caregivers who, on average, might rely more on social support. Moreover, transnational mobility was reduced or even stopped (also see Blower and de Leon, Noack and Bilecen in this special issue). Further, the exchange with relatives and friends as a coping strategy to handle stress and informal support was reduced, linked to an increased burden for migrant caregivers. Taken together, all this would have resulted in more severe negative health outcomes for migrant caregivers in pandemic times. Wellbeing effects, however, likely differed significantly between (non-) migrant caregivers across Europe not least due to the broad variation in COVID-19 mitigation measures whose differential (side) effects still merit substantial further research (also see Amelina, Barglowski, and Bilecen 2024 and Sime in this special issue).

To the best of our knowledge and to date, empirical studies on changes in caregiving burden during the pandemic focussing on migrant family caregivers across Europe do not exist. Most studies addressing "care and migration" during the pandemic focussed on so called "live-in" carers (individuals who mostly on a temporary base live with impaired older people and help them with daily tasks and hands-on care), and what changed for them due to COVID-19 (e.g. de Diego-Cordero et al. 2022; Giordano 2021; Kuhlmann et al. 2020; Leiblfinger et al. 2020; Leiblfinger et al. 2021). Taken together, even though there is considerable movement, further research is direly needed to thoroughly assess the wellbeing changes for (non-) migrant caregivers during the pandemic and potential buffers during such crises.

Limitations and paths for future research

As we have shown, there are many reasons to believe that migrant caregivers to older relatives are – on average – in a different situation than the autochthonous population. When trying to assess the specific situation of migrant caregivers and related burdens, however, the need for more fine-grained theorizing and better longitudinal data on these sub-group/s becomes very obvious: at the intersection between caregiving and migrant status from different backgrounds within different contexts we are left with very little theory-driven expectations and empirical information.

Those different theories addressing caregiving by migrants to their family members or friends and those relating differences in caregiving behaviour to wellbeing remain rather vague. As demonstrated above, it is often argued that differences in wellbeing outcomes due to caregiving can be expected i. between migrant caregivers and non-migrant caregivers, ii. between different groups of migrants, and iii. across migrant generations. However, it is not spelled out how exactly such differences would look like in different countries across Europe, and many assumptions are not discussed or explicitly presented. This is presumably partly due to the fact that ageing societies and welfare regimes in Europe are complex in their nature. In particular, there is a high degree of heterogeneity in the group of migrants, which makes the establishment of a universal theory for migrant care and wellbeing a difficult if not impossible undertaking.

The data landscape for empirical studies unfortunately bring about similar challenges, as is demonstrated by the scarce (quantitative) empirical evidence on migrant populations. There is no comparative longitudinal data of a representative and large enough sample of individuals who migrated (interviewed in their respective native language) to address such issues in a meaningful manner. Surveys, which oversample the migrant population (at least in a cross-section within one country), do not pay attention to the

older population and their care relations (see, e.g. the GSOEP migration sample, Brücker et al. 2014). Longitudinal and comparative surveys which focus on the older population and care patterns only broadly account for (any) migration in terms of interview languages as well as questionnaires (see, e.g. the SHARE data, Hunkler et al. 2015). As a result, migrants interviewed in survey studies are often a relatively young, highly educated sample from more Western contexts, and our related analyses likely underestimate care likelihood, care intensity and care burden due to the small number of older non-native speakers from lower SES groups (even more than we do for the autochthonous older population; see, e.g. Brandt et al. 2018 for an assessment of empirical challenges in ageing research, and Bilecen and Fokkema 2022 specifically on research with older migrants). Often, due to the lack of sufficient observations in quantitative datasets, as shown above, migrants have to be broadly grouped into categories (Western/Non-Western contexts) which do not allow for any detailed assessment of (the influences of) family values and support norms. Over and above, within-group differences in migrant groups can often not be addressed; e.g. and it is not possible to investigate different care relationships (to parents, to partners, etc.) in depth.

Taken together, we have very little comparative knowledge about the specific situations of migrant caregivers in and from different countries and regions and their changes during pandemic times, let alone the (causal) effects of migration on support behaviours, the influences of family support (needs) on (re-) migration, and selection into migration based on support patterns and relations. To assess such mechanisms, we would even need information spanning the time before and after (re-) migration (also see Bordone and de Valk 2016; Kaschowitz 2020).

Such knowledge would be essential in times of rising care needs, declining potentials, a rising number of migrants ageing in their destination country, multiple crises and potentially rising migration to European countries in future. Our first overview of models and empirical evidence on wellbeing effects of care in migrant families not only during recent crises and focussing European comparative studies shows: There is a dire need for more comparative policy analyses of (migrant) care regimes and contexts (for challenges in measuring care regimes, see, e.g. Verbakel et al. 2022), more theoretical specifications of migration-specific care behaviours, norms and values over the life course and migration generations, and comparable qualitative as well as quantitative longitudinal data from migrant caregivers, the care receivers and their support networks and formal support uptake in different countries. In order to be able to achieve the sustainable development goal of (individual and societal) wellbeing for all, we need more theory-driven empirical social research based on thorough research infrastructures, methods and data, allowing for intersectional analyses of different subpopulations. When

trying to reach secure healthy ageing across different contexts during times of multiple crises, evidence-based diversity-sensitive policy advice is urgently needed; especially for the groups at highest risk of exclusion and potentially detrimental health outcomes such as caregivers in the lower SES migrant community. Our article presents a first step in this direction by providing a possible framework for promising directions in research on care and well-being in migrant families.

Notes

1. We are well aware about the strand of research on caregiving by minority groups and wellbeing outcomes in the US, but in our opinion, it is difficult to compare such minority groups (like Blacks or Hispanics) with older migrants in the European context.
2. Some more research to examine potential differences in wellbeing outcomes between caregivers from different ethnic minorities stems from the U.S. (e.g., Cichy, Stawski, and Almeida 2014). It is, however, difficult to transfer these results to the European context as inequalities which could lead to different health outcomes of caregiving exist between different ethnic groups in the US.

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