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# Care Services for Older People in Europe - Challenges for Labour



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## 1. Preface

This report is published (March 2011) at a time when Europe stands at a crossroads. The economic crisis, austerity measures and the proposed European economic governance package risk not only to increase poverty and social exclusion but to have a devastating impact on the potential to build a sustainable and cohesive Europe.

As the report notes, there is growing demand for more and better care services to address the needs of an ageing population. Potentially, Europe has the capacity to create millions of well-paid, good jobs delivering much needed services to older people and people needing long-term care. A regulated, formal care sector has the advantages of achieving high employment rates, quality jobs with decent working and employment conditions and giving possibilities for men and women to combine professional and family responsibilities. It is also often a preferred choice of older people themselves. However, in countries where formal care provisions exist, these risk being decimated because of cuts, imposed by governments as a result of wrong policy choices. In others, as our report shows, there is literally no public spending on formal care, with the gap filled by a mix of individual arrangements. Such arrangements often provide insecure jobs and poor quality care. They also often involve female migrants in out-patient care as care workers and family assistants with low pay, reduced or no labour and social rights, partially lacking a residence and/or work permit.

As Commissioner Damanaki said in the joint EPSU/ETUI conference on the austerity measures in February 2011: *“Employment is crucial for our future.... We need to care about creating jobs now, because growth alone won't bring new jobs automatically. An IMF study showed that a 2.5% growth rate is just enough to maintain current employment, let alone to create new. So, in the absence of a prospect of high growth rates, we will have to intervene..... Public spending cuts can be more selective and spare the transfers to the vulnerable population groups as much as possible. On the revenue side, raised tax should not only serve to reduce deficits and pay interests, but to support recovery and job creation. We should support employment actively, through tax incentives and monetary or fiscal policy that stimulates job-creation.”*

The EU should seize the challenge of creating good quality and secure employment in the eldercare sector with both hands. In the report we make a number of recommendations about how this can be done. As underlined in a statement on the legal, policy and quality framework for social services at European level issued in January 2011 (<http://www.epsu.org/a/7310>) EPSU calls upon the relevant bodies in the Member States and European institutions to make full use of the new EU legal framework when designing and implementing policy initiatives, action plans and/or funding programmes. We suggest giving priority to the elaboration of specific sectoral policies with tangible goals in the years to come – e.g. in the fields of long-term care for disabled and elderly, mental health, child care (to build on the Recommendation on Childcare, aiming at an implementation of the Barcelona targets) and housing in order to illustrate the potential EU added value. When developing and implementing policies to ensure and improve the quality, effectiveness and efficiency of SSGI, EPSU considers that it is important for EU institutions to give particular weight to working and pay conditions in view of ensuring decent work and quality jobs.

*Carola Fischbach-Pyttel, EPSU General Secretary*

## 2. Executive Summary and Recommendations

Over the next 40 years the proportion of the population over the age of 65 in the European Union will double, rising from 17% in 2005 to 30% in 2050 (European Foundation, 2009). The proportion of the population over 80 will increase threefold. With longer life expectancy, there are expected to be higher levels of disability and morbidity, which will increase the demand for care services. Increased female participation in the labour force has led to a reduction in the birth rate and increased demand for formal care services because women are less able to carry out informal care. Increased rates of divorce and higher numbers of single person households also make the provision of informal care more difficult. However, the majority of informal care givers are still women. There is an increased demand for care services to be delivered at home, but home care services are more difficult to inspect and regulate. Home care workers are often a fragmented labour force, difficult to organise.

### Care work

The term 'long term care (LTC)' is used in this paper to describe the many ways in which older people are cared for and supported. The OECD defines long term care as

*“a range of services for people who depend on ongoing help with the activities of daily living caused by chronic conditions of physical or mental disability” (OECD, 2005)*

The term 'care work' can be interpreted in different ways. A care worker plays several roles which require a wide range of skills, many of which are not given a high economic value. One of the most important differences is whether the care is paid or unpaid or formal or informal. The complexity of the way in which care is delivered means that labelling the different ways that care is provided is no easy task: There are examples of informal care being paid (migrant care workers in Italy) and formal care being unpaid (volunteers in the Netherlands) (Lyon & Glucksmann, 2008). The key question is whether care is

provided in a regulated framework or not. This paper focuses on the delivery of formal (regulated) care, whilst recognising that there is a relationship between informal and formal care. A decline in informal care leads to an increased demand for formal care and this process is taking place in several European countries. Care work is rarely a separate field of policy but is the responsibility of different parts of government.

### EU level

The Charter of Fundamental Rights (2002) that has become an integral part of the Lisbon Treaty recognises an entitlement to social security benefits and social services (Art. 34) but not a mandatory right. It also grants right of access to preventive health care and the right to benefit from medical treatment (Art. 35) and of access to services of general economic interest as provided for in national laws and practices (Art. 36). *Social services of general interest* can have both, according to established Community Law, an economic and a non-economic nature. As an attempt to clarify how social care services should operate, the European Voluntary Quality Framework sets out quality principles which will define relationships between service providers and users; relationships between service providers, public authorities and other stakeholders but is a voluntary arrangement. It has been adopted by the Social Protection Committee in October 2010 and aims to be a reference for defining, assuring, improving and evaluating the quality of social services in the EU. This framework should help policy-makers and public authorities to develop specific tools for the measurement and evaluation of the quality of social services, and should also improve cross-border comparability in case of trans-border provision of social services. In a parallel process NGOs across Europe under a project have elaborated a Common Quality Framework for social services of general interest (September 2010) aiming to address different aspects related to their quality. It

proposes a European concept of quality that is flexible, compatible with and complementary to existing national quality systems in the sector, and can be applied to services that are organised at the local or regional level. A draft ILO Convention on domestic work is being prepared but unlikely to become part of national legislation for several years.

#### Life expectancy

Women have longer life expectancy rates and these are expected to continue until 2050. There are also differences in life expectancy within countries between high and low income groups, with low income groups having shorter life expectancy than higher income groups. These differences in life expectancy reflect health inequalities that need to be taken into account when planning for care services for older people.

#### Expenditure

Sweden (3.4%) and the Netherlands (3.5%) spend the highest % of GDP on long term care. Many countries in Central and Eastern Europe spend less than 1.0% of GDP on long term care. The percentage of the population aged 65+ in all European countries is over 10%, with Germany and Italy both having 20% of the population aged over 65. By 2050, at least 25% of the population will be over 65 years old. In the countries of Central and Eastern Europe the percentage is expected to increase to over 30%. The percentage of the population aged 80 and over with high shares of permanent dependency is also expected to increase to at least 10%. The % of GDP expenditure on care by 2060 is expected to at least double in all countries.

#### Types of care

There are broadly three types of long term care. Institutional care may cover nursing homes and care homes run by public, private or not for profit providers. Home care, an expanding type of long term care, covers both nursing care and basic living services delivered at home. Informal or no specific formal care covers care that is provided by family or friends or a situation where an older person does not receive any care from formal providers of care.

Denmark has a reported 56% of total beneficiaries in institutional care, which is the highest national rate but Austria, Estonia, Latvia, Poland and Slovakia report 5% or less. Countries of Central and Eastern Europe have low levels of institutional care because there are few residential or nursing homes. The Netherlands (80%) and Sweden (79%) have high levels of home care, which covers nursing and social care, delivered at home. Estonia (8%), Latvia (6%), Poland (0%) and Hungary (7%) have low percentages of home care, also reflecting the lack of long term care, whether delivered in an institution or at home.

Countries in Southern Europe and Central and Eastern Europe show over 50% receiving informal care or not receiving any formal care. Estonia, Latvia, Hungary and Poland show over 80% of long term care delivered is informal care. This is a reflection of the low levels of formal care delivered as either institutional or home care services. These patterns of provision should be considered in the context of the growth in the percentage of the population aged over 65 year. With countries in Central and Eastern Europe expected to have over 30% of their population aged over 65 by 2060, the demand for care services will increase the strongest in countries where the formal provision of care is currently lowest.

There has been an expansion of long term care services delivered to the home and a decline in nursing and care homes, especially larger institutions. As part of the move towards more home based care, several countries have adopted '*personalisation of care*' policies which allow an individual to determine how long term care is delivered. Funding of long term care is a major political issue in many countries. For countries that have introduced new funding arrangements, there is concern about the long term financial sustainability of services

#### Funding for care services

Countries grouped under the heading of Continental Europe use mainly social insurance and some taxation to pay for

social care. Long term care systems within the Nordic regions are all tax based but there are some variations between countries. All share an assumption that the state has a responsibility for looking after children, people with disabilities and older people.

Both the United Kingdom and Ireland use a tax based system with extensive private provision. This is in contrast to the Nordic region, where there is still strong public sector provision. In Southern Europe, there has been a recent move from a family based model of long term care (LTC) to a tax based system. In Italy, Spain and Portugal central governments have played a role in changing LTC policy, even if delivery is the responsibility of regional authorities.

Although the model of long term care in Central/ Eastern Europe can still be described as the 'family care model', with often less than 1% of GDP spent on long term care, this model is being challenged because of changing employment patterns. There are higher levels of informal care but there are increasing pressures on families due to employment migration, an increase in the age of retirement and stricter links between regular employment and social security (Österle, 2010). The increase in demand for LTC, as changing employment conditions make informal care more difficult, putting pressures on governments to provide funding and new policies on LTC. There is a perceived lack of access to residential care (Österle, 2010).

The accuracy of predicted levels of care also has implications for assessing the costs of care. Within the last five years, there are signs of a growing consensus on the need for governments to play a key role in funding or facilitating the funding of long term care.

#### Provision of care services

Multi-national companies are involved in care services in several ways. Many multinational social care companies own a

mix of care homes as well as some clinical services, most usually mental health services. Facilities management MNCs are increasingly becoming involved in the delivery of homecare services, for example, ISS, Sodexo. Some companies, not always involved directly in care, provide luxury retirement apartments with a range of services. The services may cover care but also include recreational activities for people on higher incomes.

The not-for-profit sector is also a major provider of care in residential and home settings. Not-for-profit organisations, such as the Red Cross and Caritas, are major providers of care in many European countries, and they do not necessarily have a tradition of unionised staff.

#### Workforce

The health and social care workforce, which includes workers in the long term care sector, is one of the fastest growing economic sectors in Europe, generating about 5% of the total economic output of the European Union. Between 2000 and 2009, there was a net increase of 4.2 million jobs resulting in 21.4 million jobs in this sector (European Commission, 2010). These jobs are not evenly distributed throughout the European Union but were found mainly in countries in Western and Northern/ Southern Europe. Countries of Eastern and Central Europe are not experiencing the same rate of expansion.

The long term care services workforce has a majority of women workers in all countries, who are predominantly low paid. The workforce is also ageing in many countries as young people are reluctant to enter the sector. In some countries, at least half the workforce is aged 50 or above. This will place a strain on the supply of labour for long term care services. Recruitment and retention is already difficult because of low pay, the low status of caring as an occupation and poor working conditions. In many European countries, the shortage of local labour has led to the use of migrant labour in care services.

Although the proportion of migrant care workers is relatively high in Austria, Italy and the United Kingdom, this is not a stable situation. Changes in national immigration policies can restrict the number of migrant workers relatively quickly. The employment rights that workers from Eastern and Central Europe gain on entry to the EU, have led workers to move to more Northern European countries, rather than neighbouring countries in Europe. Polish workers in the period immediately after EU entry moved to the UK and other Northern European countries. However, with the recession, there has been a move back to Poland. New migrants from Latin America or Africa are beginning to replace some groups of European migrant workers.

#### Trade union organising

Perhaps one of the most important features of care work is that, as well as physically demanding tasks, such as lifting and turning, there is an essential emotional element which distinguishes it from many low paid jobs. It is difficult to be a care worker without having some type of emotional relationship with the service users. This means that the job is not just done within specific working hours but can stay with a care worker during non-work time.

The majority of contracts are full time although there are some countries, such as Norway and Sweden that have between 40% and 50% part time contracts. Care workers for older people in the public sector are likely to be covered by a collective agreement, with the exception of Ireland, where all workers have taken a 15% pay cut and national collective arrangements have broken down. Workers in the private sector are covered by a collective agreement in the Netherlands and Nordic countries. Agency workers, self employed and short term contracts are most likely to be found in the private or not for profit sectors. As there is a move from public to private provision, these worsened contractual arrangements are expected to affect an increasing number of care workers.

Levels of unionisation vary from country to country. There is no clear relationship between coverage by a collective agreement and the level of unionisation, although the Nordic countries have high levels of unionisation and often 100% coverage by a collective agreement in the public sector. The Netherlands, with 100% Collective agreements in both public and private sectors has a much lower level of unionisation in the public, private and not for profit sectors. Countries in Central and Eastern Europe have much lower levels of unionisation.

The provision of care services for older people is a labour intensive activity. Care workers are employed by public, private and not for profit employers. There is a growing trend for greater provision by private and not for profit providers. The survey of collective bargaining agreements across Europe shows that, with some country exceptions, the coverage of care sector workers is weakest in the private and not for profit sectors. This provides the first challenge for trade unions.

The second emerging issue which will inform organising in the future is the expansion of home care workers. There is a growing demand for care to be delivered in people's homes. The financing of care through personalised budgets is contributing to an expansion of individual home care workers who are either self-employed or contracted directly by an older person receiving a care allowance. The expansion of workers who are not employed directly by a large employer makes negotiating collective agreements difficult for trade unions.

Trade unions will have to explore different approaches to organising a fragmented workforce at local and national levels, particularly organising part-time women workers.

#### Training

There have been some significant changes in the provision of training for long term care workers, which have been influenced by developments at European Union level as well as a recognition that

improved training will help to ensure higher rates of retention and recruitment. At EU level, legislation and directives on the promotion of vocational training and the free movement of workers have had an impact on the provision of training for long term care workers. Directive 2005/36 covers the mutual recognition of qualifications. Several countries have introduced new systems of training for care workers, which are contributing to a gradual process of professionalization (Moss et al, 2004). Trade unions in almost all countries are involved in processes of consultation about training and qualifications. Several unions have places on Advisory Boards and other are actively involved in the development new forms of training and professional development. The expansion of home care work makes the lack of clarity about training a serious problem for future recruitment and retention.

#### New ways of working and new services

Social dialogue, improving quality standards and training are three of the main areas where trade unions have been active in developing new ways of working. New services that meet the changing needs of an ageing population will have to be designed in partnership with older people. Services will have to move away from just having a focus on care to covering a broader range of activities, such as information provision, education, training and physical activity. The emphasis will have to be on cooperation with older people. This also returns to the wide range of approaches that inform the design of care services, including social

pedagogy. The integral part that education plays in child care will have to be replicated in care services for older people. This will impact on the type of training required for care workers.

#### Conclusion

Care services for older people are evolving in many countries but care work is still an occupation that has a predominantly low paid, female workforce. Reforms to the system of payments for older care have been adopted by several countries. In other countries, discussions are taking place, with recognition that an adequate system of older care provision is a priority. Some countries are making the transition from a family model of care to a more diverse form of formal and informal care.

The increase in home care, where care is delivered to an individual's home, whether by public, private or not for profit providers or self employed carers, can be seen in the majority of countries. The changes in society which are supporting the demands for more individual personalised care delivered at home are challenging the convention model of institutional care homes, even though these still provide a significant amount of care. However personalisation is also leading to the creation of new types of jobs which are often unregulated and unprotected. One of the major challenges for trade unions will be how to organise and negotiate terms and conditions for these new groups of home care workers or personal assistants.

## **Recommendations to the EPSU Standing Committees for Health and Social Services and Local and Regional Government**

### **1. Personalisation/ home care policies**

- Monitor the implementation of personalisation/ home care policies on the care workforce, country by country
- Review the experience of trade unions in organising fragmented workers
- Prioritise ways of sharing learning to organise home care workers at local, national and European level
- Address issues concerning migrant health care workers and family assistants, including undocumented care workers

### **2. Pay**

- Build on existing work to address gender pay gap
- Tackle low pay, setting lowest remuneration floors, increasing minimum wages that are clearly beyond a living wage
- Improve the quality of jobs, reducing precarious employment and the share of atypical contracts

### **3. Qualifications and training**

- Identify the extent to which qualifications are not recognised and the link to underlying racism in the care workplace
- Take European level action on training and the recognition of professional qualifications by focusing on the implementation of the Directive 2005/36/EC
- Develop alliances with other health and social professionals to strengthen campaigning position

### **4. Quality framework**

- Engage with governments, employers, and civil society to build on the positive elements of the European Voluntary Quality Framework (EVQF SSGI) developed and endorsed by the Social Protection Committee (SPC) and the Common Quality Framework (CQF SSGI) elaborated in the framework of the Prometheus Project, in particular in view of elements concerning employment and working conditions, the quality of services and their regulation and financing

### **5. Promoting care work**

- Promote the value, image and recognition of care work through campaigns and joint initiatives with not for profit and other institutions
- Build on cooperation between trade unions to deal with problems emerging from the internal EU labour market in care, most probably promoted by the Directive on patients' rights to cross-border healthcare (most probably voted within the next months) and the lifting of all restrictions as to free movement of workers except for Romania and Bulgaria by May 2011.
- Build on cooperation between trade unions to deal with challenges emerging from the increasing role of (legal and undocumented) health care workers and family assistants, not least in view of their very low level of unionisation.
- Explore the development of social dialogue in the care sector at European level, building on national and local arrangements.

### 3. Introduction

Over the next 40 years the proportion of the population over the age of 65 in the European Union will double, rising from 17% in 2005 to 30% in 2050 (European Foundation, 2009). The proportion of the population over 80 will increase threefold. There are a range of implications for policy priorities, the planning of care offered and the staff profile needed as this age group is most likely to become dependent on a permanent basis and/ or to suffer from chronic degenerative disease. With longer life expectancy, there are expected to be higher levels of disability and morbidity, which will increase the demand for care services. Gradations in life expectancy between social classes and income groups mean that some groups will experience higher levels of disability and morbidity. Increased female participation in the labour force has led to a reduction in the birth rate and increased demand for formal care services because women are less able to carry out informal care. Increased rates of divorce and higher numbers of single person households also make the provision of informal care more difficult. However, the majority of informal care givers are still women. There is an increased demand for care services to be delivered at home, but home care services are more difficult to inspect and regulate. Home care workers are often a fragmented labour force, difficult to organise.

This report was commissioned by the European Federation of Public Service Unions (EPSU) to inform a joint workshop of the EPSU Local and Regional Government and Health and Social Services Committees held on 27 October 2010, in Luxembourg. The objectives of the research were to:

1. Map types and providers of care services for older people by country;
2. Identify employment trends and industrial relations, including employment growth, formal and informal employment, skills and training, working conditions and work organisation;
3. Identify key issues which can inform EPSU affiliate national and European strategies.

The data was gathered through a questionnaire survey of EPSU affiliates. This was circulated in May and responses were gathered over the following two months. A total of 16 responses were received. A list of respondents can be found in Appendix A. Additional information and data was collected from institutional, academic and policy research. The results of the workshop discussions have been added to this final report.

This paper is structured in the following sections:

- Concepts of care
- European policy context
- Policies, funding and provision at national level
- Labour markets for care workers
- Working conditions
- Training / qualifications
- New services and ways of working
- Conclusion and recommendations

## 4. Concepts of Care

The term 'long term care (LTC)' will be used in this paper to describe the many ways in which older people are cared for and supported. The OECD defines long term care as

*“a range of services for people who depend on ongoing help with the activities of daily living caused by chronic conditions of physical or mental disability” (OECD, 2005)*

The term 'care work' can be interpreted in different ways. One of the most important differences is whether the care is paid or unpaid or formal or informal. The complexity of the way in which care is delivered means that labelling the different ways that care is provided is no easy task: there are examples of informal care being paid (migrant care workers in Italy) and formal care being unpaid (volunteers in the Netherlands) (Lyon & Glucksmann, 2008). The key question is whether care is provided in a regulated framework or not. This paper will focus on the delivery of formal care, whilst recognising that there is a relationship between informal and formal care. A decline in informal care leads to an increased demand for formal care and this process is taking place in several European countries.

The status of older people in society also influences approaches to care of older people. Moss (2004) observed that care work with children has a “*richer historical tradition*” than work with older people, perhaps a reflection of different attitudes to children and older people. Across Europe, there are a range of different types of care services for older people provided by public, private and not-for-profit providers. There are also some significant country differences in the approaches to long term care (LTC) work, which are influenced by national welfare state developments, the move from institutional care to community and home based care, as well as different philosophies of care.

This paper starts by drawing from research, which has tried to explore different approaches to care, described in terms of:

- Social pedagogy and education;
- Social welfare;
- Social models of disability;
- Human rights.

These approaches are not mutually exclusive and together influence how services are designed. Social pedagogy has a long history in some European countries, and it plays a strong influence in service delivery. In many countries, long term care for older people has moved away from a social welfare approach, where people were provided with care as a result of social security contributions made through their working lives, to a more active recognition of an older person's human rights, when receiving care. A social model of disability is also used to inform service delivery, by recognising that the biggest barriers that people with disabilities face are social attitudes to disability.

Social care is often used as an administrative term, which covers both home and institutional care. The tasks cover physical care but also include ‘*enabling*’ older people to be independent and as active as possible. The delivery of care involves some form of relationship with the older person (Moss, 2004: 6). Increasingly, social care is delivered in people's own homes. Care services for older people contribute to:

- A good family life;
- Providing protection;
- Supporting citizenship.

As a result, a care worker plays a number of roles, which draw from a wide range of skills, as:

- An ethical human being;
- A mentor;

- A professional person with judgement;
- A service provider (Hansen & Jensen, 2004)

These are all complex and demanding roles which are not widely valued by European societies. They all demand a level of '*emotional*' labour and are most often performed by women.

Care work is rarely seen as a separate field of policy. As care covers many activities and roles, it is often placed under the responsibility of different parts of government, in different countries. Policy is defined in relation to different age groups and/ or types of services. These governmental differences in responsibility result in the use of a range of terms, such as social protection, social welfare and social care, to cover the budgets and agencies responsible for care services for older people. This can make comparisons across European countries difficult but there are common elements of care for older people that are identifiable in most countries.

#### Key points

- Several different approaches to care inform care services for older people
- A care worker plays several roles which require a wide range of skills, many of which are not valued
- Care work is rarely a separate field of policy but is the responsibility of different parts of government
- Comparisons across Europe are difficult but there are common elements of care for older people that are identifiable in most countries

## 5. European policy context

The European Union has developed policies that impact on older people even though social care is the responsibility of national Member governments. The European Union leads research and policy debates into the impact of an ageing population on the future of Europe.

In 1996, the Turin Social Charter of the Council of Europe agreed to establish a mandatory right to social services. In the 1<sup>st</sup> EU Convention (2000) and the draft European Constitution (2003), this mandatory right was abolished, as was the right to social assistance. The Charter of Fundamental Rights (2002) has a section on social security and social assistance, which recognises an entitlement to social security benefits and social services.

*“The Union recognises and respects the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age, and in the case of loss of employment, in accordance with the rules laid down by Community law and national laws and practices”* (European Parliament, 2000).

This indicates that although the demand for social care services in Europe will continue to expand with an ageing population, the rights to social services and social assistance cannot be assumed to be protected in future. The recognition of entitlement is a much weaker commitment to universal access than a right to social services.

An important issue is whether social services are protected from competition and the internal market laws in the EU. Access to social services will be affected if social services are considered a Service of General Interest (SGI) or a Service of General Economic Interest (SGEI). This has been subject to extensive political debate and the issue is still not resolved. The draft Services Directive (June 2004) *Services in the internal market COM (2004)* recommended that “*personal social services*” be considered a Service of General Economic Interest (SGEI). If this had been agreed then social care services would have been subject to competition law. The final version of the Services Directive, approved by the European Parliament, excluded healthcare entirely but only partly social services: Article 2 (j) of the Directive excludes “*social services relating to social housing, childcare and support of families and persons permanently or temporarily in need which are provided by the State, by providers mandated by the State or by charities recognised as such by the State*” and recital 33 expressly says , “*the services covered by this Directive concern a wide variety of ever-changing activities, including.....and, to the extent that they are not excluded from the scope of application of the directive, household support services, such as help for the elderly*”. There is much debate about the implications of the wording of the exclusion of social services See EPSU note on the transposition of the Services Directive <http://www.epsu.org/a/3144>

With the ratification of the Lisbon Treaty there is an important new legal basis for SGEI, Art. 14. It is being addressed to both the Union and the Member States that both, “*each within their respective powers and within the scope of application of the Treaties, shall take care that such services operate on the basis of principles and conditions, particularly economic and financial conditions, which enable them to fulfil their missions. The European Parliament and the Council, acting by means of regulations in accordance with the ordinary legislative procedure, shall establish these principles and set these conditions without prejudice to the competence of Member States, in compliance with the Treaties, to provide, to commission and to fund such services*”. The exact interpretation of what “regulation” should mean in this context is far from clear, different interpretations exist. In addition the implications for the distribution of competencies and the right or obligation to take an initiative to legislate are controversial: The same holds when it comes to expectations vis-à-vis the European Commission to embark on legal initiatives based on this Article or to refrain from binding action.

The Protocol Nr. 26 on Services of General Interest (SGI) attached to the Treaty of Lisbon (that entered into force on 1 December 2009) aims to clarify the approach to Services of

General Interest. In Art. 1 it highlights that the shared values include “*the essential role and the wide discretion of national, regional and local authorities in providing, commissioning and organising services of general economic interest as closely as possible to the needs of the users*”; and “*a high level of quality, safety and affordability, equal treatment and the promotion of universal access and of user right*“. It also states in Art. 2 that “*The Provisions of the treaties do not affect in any way the competence of member States to provide, commission and organise non-economic services of general interest*” (European Union, 2007).

However, recent Communications, including COM(2007) 725 (22 November 2007) on “*Services of General Interest, including social services of general interest: a new European commitment*”, suggest that social services can be considered both as an economic and a non-economic Service of General Interest (European Commission, 2007). This new Communication sets out a strategy for social services, across the EU, and this can be seen as indicative of the European Commission perspective that implicitly and explicitly supports trends towards setting up and regulating quasi markets that in the field of health and social services are often referred to as “social markets“. These developments exist since the 1990ies across Europe and have been initiated by governments at national; regional and local level in the framework of New Public Management (cf. Huber/Maucher/Sak 2008, Commission of the European Communities 2008, Commission of the European Communities 2010b).

In 2006, the European Commission (EC) had identified two categories of Social services of general interest (SSGI). The first category covers statutory and complementary social security schemes (mutual or occupational), which cover the main risks of life. Ageing is included as a ‘*risk of life*’. The second category covers services provided to the individual, which aim to promote social inclusion and play a preventive role. Care services for older people are included but the range of services is much wider, in terms of age and type of disadvantage (European Commission, 2006). In this document the Commission put health services into a third category and announced that they would be dealt with under parallel, but separate legal and non-legislative initiatives.

There has been a significant shift in the underlying attitude of the EU towards people receiving social services. People are no longer seen as just recipients of services but have become people with rights (UN, 2006), users with the right to participate and to be involved in decisions concerning them, people to be empowered towards more self-direction over their lives where possible and appropriate. However, no quality standards have been set for SSGI at European level.

The European Union in late 2010 adopted a European Voluntary Quality Framework (EVQF SSGI) to establish common principles and guidelines for care services in countries across Europe. It proposed the development of a “*voluntary EU quality framework providing guidelines on the methodology to set, monitor and evaluate quality standard*“. The EQPF SSGI is designed in a manner and with the purpose of being compatible with, and complementary to, already existing general or sector-specific quality approaches and quality management systems within member states. It has been developed and endorsed by the Social Protection Committee (SPC) in October 2010 and was finally adopted by the EPSCO Council in December 2010.

It sets out quality principles which will a) define relationships between service providers and users; b) relationships between service providers, public authorities and other stakeholders; and (c) human and physical capital (Social Protection Committee, 2010). Although these are drawn from the experience of local, regional and national providers of social services, one of the weaknesses of the European Voluntary Quality Framework is that there are no specific targets that providers have to meet and no formal monitoring procedures. This is particularly difficult when issues of training and professional development are mentioned, which should be mandatory. The voluntary nature of the EVQF SSGI can be explained on the one hand by

demands of member states that wanted to make sure that their subsidiarity and the division of competencies are respected. On the other hand it is due to its complementary character and the fact that it comprises and promotes principles and guidelines, not technical standards. Legal regulations on quality standards fixed at national, regional or local level and existing quality management and assurance systems should be underpinned and improved, where appropriate, by making use of the EVQF SSGI. Another shortcoming is that there is no specific section on framework requirements for quality (such as sufficient and sustainable financing, qualified staff, cooperation and partnership in delivering services on the ground) and that only some elements needed to safeguard decent working conditions and quality jobs are dealt with. The document, however, makes reference to the Commission's Recommendation on active inclusion of October 2008 which in a mid-term perspective could allow giving more weight to initiatives aiming at the improvement of the quality of services and employment.

In a parallel process involving a range of stakeholders, mainly social NGOs, the European Committee for Standardisation (CEN) supported the elaboration and dissemination of a Common Quality Framework for social services of general interest (CQF SSGI). The CQF SSGI has been developed during 2009 and 2010 in the framework of a project (Prometheus Project 2010). It aims to address different aspects related to quality of personal social services in different sectors. The CQF SSGI proposes a European concept of quality that is flexible, compatible with and complementary to existing national quality systems in the sector, and can be applied to services that are organised at the local or regional level. In a separate section it deals with preconditions needed to organise, deliver and finance social services, amongst them a supportive social policy and legislative framework, sustainable financing, stakeholder dialogue, affordability, accessibility and availability. Taking into account feedback and votes obtained through an online consultation, CEN in September 2010 decided not to endorse the CQF SSGI as a CEN Workshop Agreement. The quorum usually needed to do this step had not been attained. There was also insufficient political support amongst a number of key stakeholders involved in the process (including EPSU) in view of this formalisation of the outcome of the project and the CEN Workshop. It remains to be seen what impact the CQF SSGI will have at European level and within member states.

The European Commission (EC) recognises the value of 'healthy ageing' policies. This has been addressed through the Lisbon Treaty, the Sustainable Development Strategy as well as the Open Method of Coordination (Healthy Ageing in Europe Conference, 2009). The first objective of the European Health Strategy is to "*foster good health in an ageing Europe*". The EC has focused mainly on the determinants of health, including smoking, nutrition and physical activity. In 2010-11, the EC is expected to produce a Healthy Ageing paper, which will set the objectives for a healthy ageing policy at EU level (Healthy Ageing in Europe Conference, 2009). In 2011 the European Commission together with a broad range of stakeholders will launch, in the context of the Innovation Europe Flagship Initiative under the Europe 2020 Strategy, a European Innovation Platform "Active and Healthy Ageing" (<http://www.epsu.org/a/7304>). It will concern trade unions and the interests of workers and employees in the health care and social services sector in dealing with integrated service provision and the sustainability and efficiency of health and social care systems. The year 2012 has been designated as the European Year for Active Ageing and Intergenerational Solidarity (Commission of European Communities, 2010c). DG SANCO announced an Action Programme on the health care workforce to be elaborated and endorsed during 2011.

In June 2010, the governing body of the International Labour Organization (ILO) adopted a resolution calling for the drafting of an international Convention and supplementary Recommendation to extend labour standards and social protection to the world's domestic workers (ILO, 2010). The ILO is an international organisation that has the potential to influence working conditions in the long term care sector through the use of Conventions, which are ratified by national governments, a process which often takes several years. Once ratification has taken place, it is up to individual governments to implement the

recommended legislation. An ILO Convention on domestic work would provide an extra focus for campaigning for home care workers in Europe.

#### Key points

- European Union leads research into implications of ageing population
- The Charter of Fundamental Rights (2002) recognises an entitlement to social security benefits and social services but not a mandatory right
- *Social services of general interest* can have both an economic and a non-economic dimension, according to Community Law and ECJ rulings. As both build on a functional approach when it comes to the concepts of “economic activity”, “enterprise” and “service” one is safe to conclude that all health and social services provided by professional staff and being part of a system of at least partial reimbursement of costs by public authorities or social protection schemes have to be considered as “economic activity” according to the approach explained above. They therefore all are in principle subject to Community law in the fields of competition, state aid, public procurement and internal market. Exemptions and specific thresholds, however, can apply.
- A European Voluntary Quality Framework (EVQF SSGI) (October 2010) sets out quality principles and guidelines which will define relationships between service providers and users; relationships between service providers, public authorities and other stakeholders. It is a voluntary arrangement. There are no specific targets that providers have to meet and no formal monitoring procedures. This is particularly difficult when issues of training and professional development are mentioned, which should be mandatory. It does not contain a separate section on framework requirements for quality (such as sufficient financing, qualified staff, cooperation and partnership in delivering services on the ground) and only a few elements on decent working conditions and quality jobs are being dealt with.
- The Common Quality Framework for social services of general interest (CQF SSGI) (September 2010) is expected to also be influential and instrumental when it comes to shaping issues related to the quality of SSGI at EU level and within member states as it embraces a comprehensive and complementary approach, open to application in different sectors of health and social services provision.
- Focus on healthy ageing policy and an ageing health care workforce (in the framework of a European Action Plan on the health care workforce to be set up and endorsed during 2011) expected in 2010-2012
- 2012 European Year for Active Ageing and European Innovation Partnership ‘Active and Healthy Ageing’ launched in early 2011 under the ‘Innovation Europe Flagship Initiative’
- Draft ILO Convention on domestic work is being prepared but unlikely to become part of national legislation for several years

## 6. Policy, funding and services provision at national level

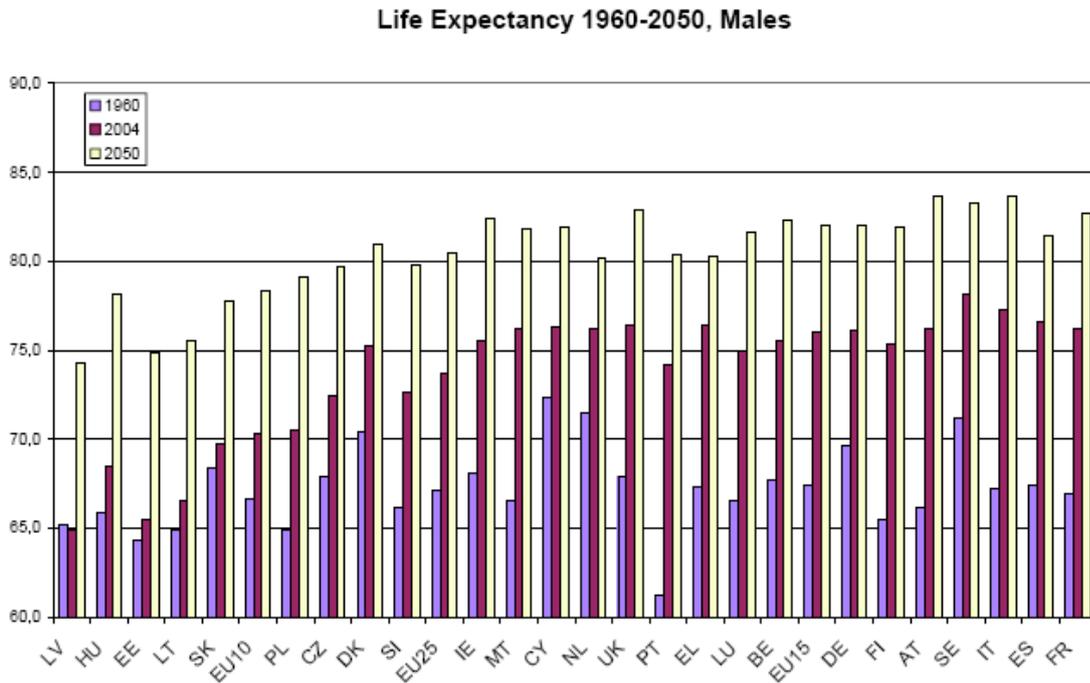
Long term care provision in Europe is characterised by a mix of family, market and state provision. All countries have some informal care, complemented by various types of formal services, funded by taxation, social insurance and / or private insurance. Long term care services have become increasingly commodified, as each service has been broken down into a series of tasks that can be costed rather than considered as a complete service, assessed on quality measures. This applies to long term care services delivered as public services or by the private or not for profit sectors (Le Bihan and Martin, 2010). Services are increasingly delivered at home and not in institutional settings. The interface between health and social care is an important influence on both the financing and provision of social care services in many countries because they are often financed in different ways and because nursing care may be categorised as both health and social care.

There are extensive debates about how to classify national systems and the extent of the similarities and differences between countries (Esping-Andersen, 1990 Arts and Gelissson, 2002). In this paper, countries will be grouped into five major sub-regions, according to history and national system of funding and services provision.

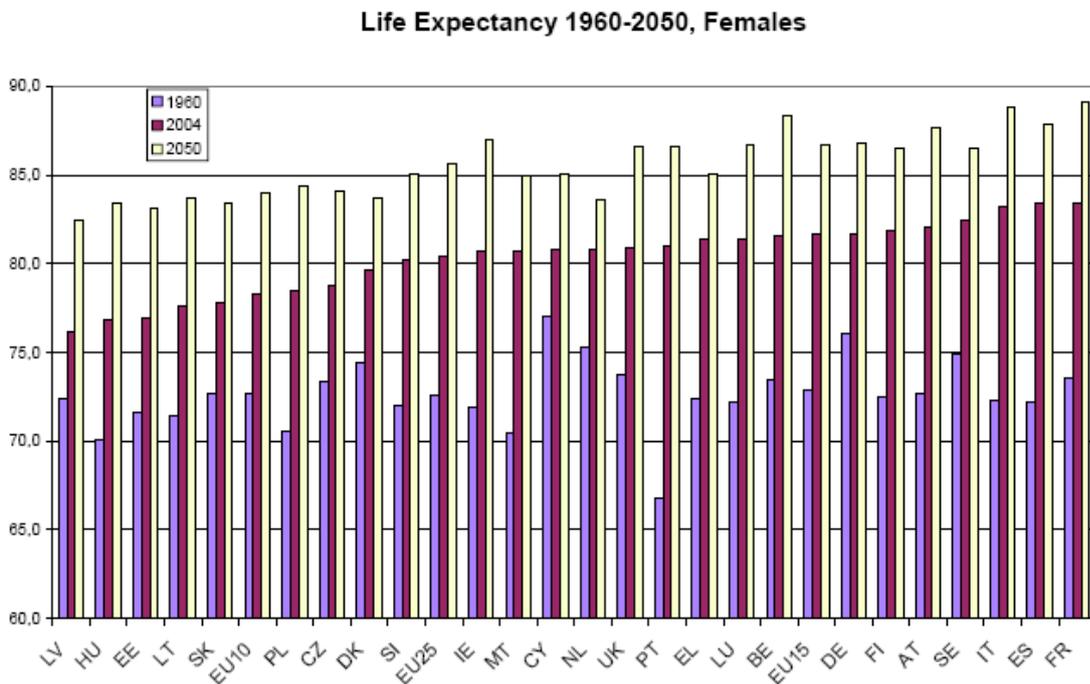
- Continental Europe – social insurance and some taxation
- Nordic region – taxation
- UK/Ireland – taxation and mainly private provision
- Southern Europe – moving from family support model to state assessment and mixed provision
- Central and Eastern Europe – family support model

This section on national policy, funding and services starts with an examination of the percentage of Gross Domestic Product (GDP) spent on long term care funding. This percentage is compared to two scenarios that predict the percentage of GDP which will be needed for long term care in 2060. The first scenario is described as the '*pure demographic scenario*' which is based on the hypothesis that life expectancy increases because of new technologies that help to save lives but longer life expectancy does not lead to improved health (Grenberg, 1977 and Olshansky et al, 1991 cited in Przywara et al, 2010). A second hypothesis, called the '*constant disability scenario*' assumes that an increase in life expectancy will result in better health. People will live longer, healthier lives and severe morbidity and disability will be postponed to the last few years of life (Manton et al, 1995 cited in Przywara et al, 2010). These two scenarios predict differing levels of disability and hence the demand for long term care will be different. Before outlining the results of the two future scenarios, data on the different national life expectancy rates for men and women are set out below.

**Figure 1: Life expectancy 1960-2050, Males**



**Figure 2: Life expectancy 1960-2050, Females**



Figures 1 and 2 show that there are considerable differences in life expectancy between countries and between men and women. Women have longer life expectancy rates and these are expected to continue until 2050. There are also differences in life expectancy within countries between high and low income groups, with low income groups having shorter life expectancy than higher income groups. These differences in life expectancy need to be taken into account when planning for care services for older people.

**Table 1: Percentage (%) of GDP spent on long term care funding in 2007 and 2060, using two scenarios shown with projections for % population aged 65+ and 80+**

Continental Europe	% GDP (2007)	% pop. aged 65+ (2008)	% pop. aged 65+ (2060)	% pop. aged 80+ (2008)	% pop. aged 80+ (2060)	2060 (projected 1 <sup>st</sup> scenario)	2060 (projected 2 <sup>nd</sup> scenario)
Austria	1.3	17	29	5	11	2.5	2.3
Belgium	1.5	17	27	5	10	3.0	2.7
France	1.4	17	26	5	11	2.3	2.1
Germany	0.9	20	32	5	13	2.4	2.2
Netherlands	3.4	15	27	4	11	8.5	7.6
Nordic region	% GDP (2007)	% pop. aged 65+ (2008)	% pop. aged 65+ (2060)	% pop. aged 80+ (2008)	% pop. aged 80+ (2060)	2060 (projected 1 <sup>st</sup> scenario)	2060 (projected 2 <sup>nd</sup> scenario)
Denmark	1.7	16	25	4	10	3.8	3.0
Finland	1.8	17	28	4	11	4.5	4.2
Norway		15	25	5	10		
Sweden	3.5	12	36	3	13	6.0	5.5
Southern Europe	% GDP (2007)	% pop. aged 65+ (2008)	% pop. aged 65+ (2060)	% pop. aged 80+ (2008)	% pop. aged 80+ (2060)	2060 (projected 1 <sup>st</sup> scenario)	2060 (projected 2 <sup>nd</sup> scenario)
Greece	1.4	19	32	4	13	3.8	3.4
Italy	1.7	20	33	5	15	3.1	2.8
Portugal	0.1	17	31	4	13	0.2	0.2
Spain	0.5	17	32	5	14	1.4	1.3
UK/ Ireland	% GDP (2007)	% pop. aged 65+ (2008)	% pop. aged 65+ (2060)	% pop. aged 80+ (2008)	% pop. aged 80+ (2060)	2060 (projected 1 <sup>st</sup> scenario)	2060 (projected 2 <sup>nd</sup> scenario)
Ireland	0.8	11	25	3	10	2.3	2.1
United Kingdom	0.8	16	25	5	9	1.4	1.3
Central/Eastern Europe	% GDP (2007)	% pop. aged 65+ (2008)	% pop. aged 65+ (2060)	% pop. aged 80+ (2008)	% pop. aged 80+ (2060)	2060 (projected 1 <sup>st</sup> scenario)	2060 (projected 2 <sup>nd</sup> scenario)
Bulgaria	0.2	17	34	4	13	0.4	0.4
Czech Republic	0.2	15	33	3	13	0.7	0.6
Estonia	0.1	17	31	4	11	0.2	0.1
Latvia	0.4	17	34	4	12	0.9	0.9
Lithuania	0.5	16	35	3	12	1.1	1.0
Hungary	0.3	16	32	4	13	0.6	0.6
Poland	0.4	13	36	3	13	1.2	1.1
Romania	0	15	35	3	13	0.1	0.0
Slovakia	0.2	12	36	3	13	0.6	0.6
Slovenia	1.1	16	33	4	14	3.0	2.8

Source: European Commission/ Economic Policy Committee (2009)

Sweden (3.4%) and the Netherlands (3.5%) spend the highest % of GDP on long term care. In contrast, Romania spends nothing on long term care. Many other countries in Central and Eastern Europe spend less than 1.0% of GDP on long term care. The percentage of the population aged 65+ in all countries is over 10% with Germany and Italy both having 20% of the population aged over 65. The percentage for all countries is expected to increase to over

25%. In the countries of Central and Eastern Europe the percentage is expected to increase to over 30%. The percentage of the population aged 80 and over is also expected to increase to at least 10%. The predictions for 2060 in the first scenario are slightly higher than for the second scenario but all predictions show the majority of countries doubling the percentage of GDP spent on long term care.

There are broadly three types of long term care. Institutional care may cover nursing homes and care homes run by public, private or not for profit providers. Home care, an expanding type of long term care, covers both nursing care and basic living services delivered at home. Informal or no specific formal care covers care that is provided by family or friends or a situation where an older person does not receive any care from formal providers of care. The nature of the relationship between the percentage of GDP spent on long term care and the types of services provision by country can be seen below.

**Table 2: Types of service provision by country (% of total beneficiaries)**

Continental Europe	% GDP (2007)	Institutional Care % of beneficiaries	Home Care % of beneficiaries	Informal /no care % of total beneficiaries	% pop 65+
Austria	1.3	5	23	72	17
Belgium	1.5	30	33	36	17
France	1.4	24	23	53	17
Germany	0.9	15	28	56	20
Netherlands	3.4	20	80	0	15

Nordic region	% GDP (2007)	Institutional Care %	Home Care %	Informal /no care %	% pop. 65+
Denmark	1.7	56	34	10	16
Finland	1.8	23	25	52	17
Norway					15
Sweden	3.5	30	70	0	12

Southern Europe	% GDP (2007)	Institutional Care %	Home Care %	Informal/ no care %	% pop. 65+
Greece	1.4	15	34	50	19
Italy	1.7	6	14	80	20
Portugal	0.1	9	21	70	17
Spain	0.5	11	11	78	17

UK/ Ireland	% GDP (2007)	Institutional Care %	Home Care %	Informal/ no care %	% pop 65+
Ireland	0.8	24	55	21	11
United Kingdom	0.8	16	42	42	16

Central/Eastern Europe	% GDP (2007)	Institutional Care %	Home Care %	Informal/ no care %	% pop 65%
Bulgaria	0.2	14	30	57	17
Czech Republic	0.2	19	44	37	15
Estonia	0.1	6	8	86	17
Latvia	0.4	6	6	88	17
Lithuania	0.5	18	4	77	16
Hungary	0.3	8	7	85	16
Poland	0.4	4	0	96	13
Romania	0	11	15	74	15
Slovakia	0.2	0	12	88	12
Slovenia	1.1	13	18	69	16

Source: European Commission/ Economic Policy Committee (2009)

It is not easy to make comparisons between European countries because each country has responsibility for social care services and has different policies and practices. However, the table above shows some trends that are significant across Europe.

Denmark has a reported 56% of total beneficiaries in institutional care, which is the highest national rate but Austria, Estonia, Latvia, Poland and Slovakia report 5% or less. Countries of Central and Eastern Europe have low levels of institutional care because the social care infrastructure, such as nursing homes, is limited. The Netherlands (80%) and Sweden (79%) both have high levels of home care, which covers nursing and social care, delivered at home. Estonia (8%), Latvia (6%), Poland (0%) and Hungary (7%) have low percentages of home care, also reflecting the lack of long term care, whether delivered in an institution or at home.

The third column shows the percentage of either informal care or where no care is received. This is a difficult column to interpret because both the Netherlands and Sweden show that there no informal care delivered. It is difficult to imagine a country whether there is no informal care but it suggests that the majority of care delivered at home is through formal providers. However, countries in Southern Europe and Central and Eastern Europe show over 50% receiving informal care or not receiving any formal care. Estonia, Latvia, Hungary and Poland show over 80% of long term care delivered is informal care. This is a reflection of the low levels of formal care delivered as either institutional or home care services. These patterns of provision should be considered in the context of the growth in the percentage of the population aged over 65 year. With countries in Central and Eastern Europe expected to have over 30% of their population aged over 65 by 2060, the demand for care services will increase in countries where the formal provision of care is currently lowest.

## 7.1 Funding and services

The evolution of long term care and the funding arrangements used to pay for long term care care, by country, will now be outlined. There are several themes that emerge from a review of national profiles. There has been an expansion of long term care services delivered to the home and a decline in nursing and care homes, especially larger institutions. As part of the move towards more home based care, several countries have adopted '*personalisation of care*' policies which allow an individual to determine how long term care is delivered. Funding of long term care is a major political issue in many countries. For countries that have introduced new funding arrangements, there is concern about the long term financial sustainability of services.

Countries grouped under the heading of Continental Europe use mainly social insurance and some taxation to pay for social care. The Netherlands was the first country in Europe to introduce universal mandatory insurance (AWBZ) for long term care (LTC) in different settings. It was funded through income contributions of the working population (68%) along with state subsidy (24%) and some co-payments (9%). Initially, the AWBZ covered nursing home care, institutional care for people with mental handicaps, and long term hospital admissions of more than one year. In 1997, the AWBZ was increased to cover residential care for older people (Schut & Van den Berg, 2010).

The AWBZ covers personal care, nursing, supportive guidance to help people manage their lives, activating guidance that helps people modify their behaviour, treatment and accommodation. Entitlement to care can be in kind or through a personal care budget or both. Personal care budgets were introduced in 1995 and provided an alternative to informal care. Relatives who had previously provided informal care could now be paid to provide care. There has also been an increase in the number of brokers arranging care for individuals with personal care budgets (Schut & Van den Berg, 2010). In 2007, the Social Support Act excluded domiciliary care from the coverage of AWBZ. This was a significant change in coverage, which transferred responsibility to local authorities.

### France

A major reform to the French system of long term care took place in 2002 with the introduction of the *Allocation personnalisée e l'autonomie* (APA) which provides cash for the care of frail elderly. This has led to an increased take-up in the period 2002-2008, with the number of people claiming rising from 150,000 in 2001 to 1,115,000 in 2008.

There is a mix of public and private provision and services are delivered at home or in a residential setting. The APA is a national scheme, implemented at local level and covered by local taxes. The social security system pays the hospital and medical costs for older people and the health costs in residential homes and nursing at home. Nurses and nursing care attendants, who are independent workers or from not for profit organisations (services at home), are the main health professionals personal and medical care at home (Le Behan & Martin, 2010). In 2007, there were 2,000 nursing '*services at home*' organisations offering 88,000 places. There is a shortage of places, with 1.8 places for every 100 people aged 75+.

Social care services are also provided by public and not for profit agencies, which offer cleaning services and personal assistants to care for older people, which are organised at local level. In 2006, residential care for older people covered nursing homes, collective housing, long term care hospital services and temporary housing, with the majority of beds in nursing homes. In 2002, a new category of residential care was introduced called institutions for the dependent elderly (EHPAD) which provide accommodation and health care (Le Behan & Martin, 2010). An increasing number of companies have become involved in setting up EHPAD beds.

The APA is given to older people, who are living in their own homes or in institutions. They are assessed according to 6 levels of dependency. The APA is payable up to the 4<sup>th</sup> level. The APA is paid to finance a specific care package determined by a team of professionals who access to person needing care. This care package can be delivered by professional carers or a relative. It is means-tested and people below a certain income level do not make contributions (Le Behan & Martin, 2010). There are major issues of sustainability for funding of this system, which is funded through a mix of social insurance and taxation. The question of how to predict future demand for long term care remains an issue for planning.

The quality of care in the relative new EHPAD residential homes has been questioned by trade unions. There are differences between the terms and conditions of workers in residential/ institutional care and home care with more full time contracts in residential care and more part time contracts in home care. An increase in the employment of young people in home care services has been reported. Organising the home care workforce is difficult because it is fragmented.

### Germany

A reform of long term care insurance was introduced in 1994. It established a social long term care insurance (LTCI) and a mandatory private LTC covering the whole population. All insurance products are capped so there are private co-payments and means tested assistance, especially for nursing home care. The long term care insurance is available for people who need help with two basic activities of daily living and one additional instrumental activity of daily living for at least six months. Medical Review Board assesses for the social long term care insurance and Medicproof, a company, assesses for private insurers.

LTCI beneficiaries can choose between home care (in kind or cash), day and night care and nursing care. All providers, not-for-profit, for-profit and public, must have a contract with LTCI funds. From 1994 – 2006, the numbers of recipients of care increased from 1,826,000 to 1,969,000. As age specific dependency remained stable during this period the increase was due to demographic ageing (Rothgang, 2010).

The aim of LTCl was to strengthen home care/ family care but there has actually been an increase in nursing home care and more formal care. The number of providers has increased as has the number of employees, especially part-time workers.

**Table 3: Providers of home and nursing home care**

	Home care		Nursing home care	
	No.providers	No.employees	No.providers	No.employees
1999	10,820	183,782	8,559	645,456
2007	11,529	236,162	11,029	799,059

Source: Rothgang, 2010

In 2008, the LTC Further Development Act was passed to improve the delivery of care giving but gives an emphasis to informal care. A new '*Nursing Care Time*' was introduced along with increased promotion of rehabilitation, case management, counselling and financing. The '*Nursing Care Time*' allows for the release of family care givers from work for up to ten days (paid). It also allows absence from work for up to six months unpaid. The provision of case management is an attempt by the Federal Government to make more information about care options available through a series of information centres, an acknowledgement of the complexity of existing arrangements (Rothgang, 2010).

In Luxembourg, a dependence allowance is paid from insurance through national legislation. Care providers must have an agreement with the Ministry of Health and must offer a range of care services which are covered by insurance. Anyone who requests a claim is assessed and a decision about the number of hours of care needed is made. Care must be required for more than 6 months. A new Charter for Disabled People/ Retired People was approved in 2007, which provides rights to a decent standard of living for people with disabilities and older people.

#### Nordic region

Long term care systems within the Nordic regions are all tax based but there are some variations between countries. All share an assumption that the state has a responsibility for looking after children, people with disabilities and older people. The overall system has been described as decentralised universalism and local autonomy but delivery systems at local level vary from country to country.

In Sweden, although the central government influenced the nature of long term care through legislation, state subsidies and state regulation by the mid-1990s there was extensive decentralisation of long term care. In 1992, the ADEL reform moved responsibility for long term care from county councils to local authorities. During the period 1982 to 2006, there has been a reduction of care received by people aged 80+ from 54% in 1982 to 37% in 2006. The systems of assessment have become stricter and people have had to go outside the state system for services (Trydegard & Thorslund, 2010). There has been a decline in residential care since 2000 but municipal homes have been converted to 'senior housing'. People living in this type of housing are eligible for personal care and home nursing care but not domestic services. Higher educated older people buy this care but less well educated groups use family or informal care (Szebehely & Trydegard, 2007). There has been a decline in universal provision of care services for older people.

In 2010, new legislation, the law of freedom of choice, gave the older person the right to choose their service providers. Although it is still voluntary for local authorities to use this option, 177 out of a total of 290 municipalities have already introduced it. This new arrangement has implications for the quality of care and the unionisation of the workforce. Care workers will be employed by a much larger number of employers and this will make organising care workers more difficult.

There is a growing recognition of rights for patients but not all older people are patients. Many people will need social care support in their final two years of life. The Swedish government has invested €7million per year in a three year project to explore the quality of care. The study has found that well qualified staff are important to sustain high quality care. There is growing evidence to show that physical activity, good nutrition, feeling part of a social community, and avoiding falls and injuries can all contribute to healthy ageing. Care services for older people should be informed by the latest evidence of effectiveness, particularly in relation to preventive interventions.

#### Finland

Local administrative authorities and municipalities are responsible for regulation/ supervision of health and social care services. Municipal authorities are responsible for arranging health and social care services. The majority of services are provided by the public sector and are funded through taxation. Long term care services cover nursing homes and residential homes, sheltered housing, supported housing and home help services. About a quarter of these services are provided by the private sector. There are recommendations for staffing levels in relation to the number of people in an institution, which providers have to follow. Private providers have tried to introduce workers, with short term training, to the sector.

A National Framework for High-Quality services for older people was published in 2008, which aims to promote the health and welfare of older people and to increase quality and effectiveness of services. Decision makers and managers in both health and welfare services will use the framework to develop and evaluate services care services for older people. In 2011, a new Law on Elder Care will be introduced.

#### Norway

Norway faces many of the same issues as other European countries in that there is a growing ageing population and an ageing social care workforce. Many changes that have been introduced into the health and social care sector have led to health and social care professional spending more time on administration. Many of these tasks could be done by assistant care workers.

Services are provided by public, private and not for profit providers in all four countries. A group of private providers are gradually expanding their activities into all four countries. These cover a range of services, which include care services for older people.

#### UK/ Ireland

Both the United Kingdom and Ireland use a tax based system with extensive private provision. This is in contrast to the Nordic region, where there is still strong public sector provision.

In the United Kingdom, there have been extensive debates and enquiries into the future of long term care for older people in the last decade. These debates have not yet led to new funding arrangements. The current system of care services for older people can be described as a safety net, which provides for the poorest with highest levels of dependency. Social care is means tested, whereas health care is still free at the point of access. There are additional non-means tested benefits for older people and for full time carers. Care needs are assessed by local authorities but there is a wide variation in spending. There is a lack of transparency about eligibility for care, with older people receiving different levels of services according to where they live. Public provision has declined in the last two decades, with private and not for profit care increasing.

Institutional care in nursing or residential homes is part of a national charging system which is based on income and assets of the older person. About 4% of older people live in care or residential homes. About two thirds are funded by local authorities and a third are privately funded (Comas-Herrera et al, 2010). In the last five years there has been a move towards personalisation of budgets where the individual is given cash to purchase their own services.

In the last five years, the introduction of personalised services and personal budgets, which allow the individual older person to receive a cash payment rather than receive a service have led to the growth of a new type of carer called '*personal assistants*'. A personal assistant can be employed directly by the budget holder, by a social care budget holder (micro-employer) or be employed by a private or not for profit agency operating for personal budget holders. The personal assistant can be self-employed. There are no codes of practice on employment and pay and conditions for personal assistants and no minimum quality standards. Many individuals or micro-employers do not have any experience of employing workers. Personal assistants are an unregulated workforce providing care services for older people (UNISON, 2010).

### Southern Europe

In Southern Europe, there has been a recent move from a family based model of long term care (LTC) to a tax based system. In Italy, Spain and Portugal central governments have played a role in changing LTC policy, even if delivery is the responsibility of regional authorities.

### Spain

In Spain, the central government coordinates and provides a basic regulatory framework. There is no personal care allowance but legislation in 2007, provided a universal system where each individual has a personal right to a basic package of LTC. This was the Law on the Promotion of Personal Autonomy and Care for people in a situation of dependency, which created the Autonomy and Dependency care System (Santana, 2010). Although this was a new universal service, there was no specific tax introduced to fund this (Costa-Font, 2010). It has been funded partly through central government and partly through the autonomous regions.

Regional governments are responsible for health care and local governments for social care. Both regional and local governments use their own taxes together with block grants from the government. There are two types of publicly funded home care: a) integrated domiciliary care delivered by local health authorities, and; b) home help delivered by municipalities. Different regions have developed slightly different priorities, with some focusing on the integration of health and social care, other developing personal care policies at local level.

The issue of training is slowly being recognised as important. State and autonomous regional governments are setting levels of qualifications for workers in domestic, outreach and residential sector. Trade unions are recommending that 10-15% of workers are trained but face difficulties in implementing these improvements because the majority of workers are recruited by private agents which provide precarious working conditions where no qualifications are required, only experience. Experience cannot be credited as part of a training qualification. 60% of services are provided by private for profit providers and 20% by not for profit providers. Staff and working conditions are covered by collective bargaining agreements. Volunteers in social care undertake unpaid work for older people but are not covered by a collective agreement.

### Italy

Since 2001, and the amendment of the Constitution, regional governments have played a significant role in formulating and implementing care, with regional variations. Tuscany has introduced entitlement packages for older people with the same needs. Lombardy introduced a voucher scheme for community services which is now being questioned (Costa-Font, 2010).

Care services for older people can be provided at home, by the national health systems or municipality, or both may be integrated into a single assistance plan tailored to meet individual needs. They can also be provided to residential structures such as day centres and

assisted homes. Private residential homes are expanding to meet the needs of older people with serious health problems.

Not for profit or former public charities provide care for older people. Government run residential homes were privatised in 2000 and now operate as not-for-profit providers with independent managers but allocated by local authorities within a contractual framework. A minority have become public companies for personal services, especially residential care homes. Social cooperatives also provide social care.

In 1988, Italy introduced a companion payment or needs based allowance, which is a universal benefit, funded through central government taxation and not means tested. It could be used to pay for private services or to pay a relative. Since its introduction, there has been an increase in the proportion of over 65s who receive it. In 1991 5.0% claimed the allowance. By 2008, the proportion has risen to 9.5%. The expansion is also caused by the slow growth in institutional residential care.

Since 1991, over 7,300 social cooperatives have been founded, 59% which provide social service. Those providing care services for older people are most often found in Northern Italy. There has been an expansion in temporary work in social cooperatives. 71% of the workforce is female.

#### Portugal

Portugal has only recently introduced public provision of long term care. The majority of care provided is informal care by women. Women are increasingly moving into employment and with an ageing population, and with growing levels of chronic care, the pressure on informal care is intense (Santana, 2010).

The main providers of long term care are the Ministry of Employment and Social Solidarity and the Non-public Institute for Social Solidarity. In 2006, the National Network of Long term Integrated Care was established by law, which provides an assessment of an older person's needs after a stay in hospital. The National Network brings together health care, palliative care, social support, community services and other services. Coordination teams, based in health centres make assessments and admit people into the Network. The majority of services are provided by *Misericórdias*, which are independent charitable organisations, and private welfare institutions financed by the State (Alzheimer Europe 2009). Many families have continued to take older people home even when they have been assessed as eligible for care, but as the quality of services offered by the Network improves, this is beginning to change (Santana, 2010).

Italy and Spain have strong regional and local arrangements for service delivery. In Spain and Portugal care arrangements by the government for older people are relatively new. Central government has played an important role in providing a national policy that has made the need for formal care for older people recognised. In Italy, the influence of the companion payment is still significant but regional authorities are introducing different ways of addressing the care needs of older people.

#### Central/ Eastern Europe

Although the model of long term care in Central/ Eastern Europe can still be described as the 'family care model', with often less than 1% of GDP spent on long term care, this model is being challenged because of changing employment patterns. There are higher levels of informal care but there are increasing pressures on families due to employment migration, an increase in the age of retirement and stricter links between regular employment and social security (Österle, 2010). The increase in demand for LTC, as changing employment conditions make informal care more difficult, are putting pressures on governments to provide funding and new policies on LTC. There is a perceived lack of access to residential care (Österle, 2010).

In the social reforms of the 1990s, LTC was not prioritised. The health care sector still provides facilities that are used for long term care, for example, chronic care homes. There are long waiting lists in Slovenia and Czech Republic for institutional care. There is also limited availability of community social services. Although reforms such as decentralisation and regulation provide opportunities for LTC services, there is a lack of political will (Österle, 2010). There is a lack of basic social care infrastructure.

There is some tradition of care related payments. In Hungary, payments are made to informal carers at a level of the basic minimum pension. The Czech Republic has just introduced a care allowance. Although co-payments are made for health care, they are lower than in social care. Social care services are financed through tax based services with social assistance (Österle, 2010).

The cases of Estonia and Georgia show the type of care provision and some of the problems that face the development of care services for older people. Estonia spends 0.1% of GDP on social care, a similar level to many other Eastern and Central European countries. Residential homes are provided by central government as well as municipalities. Central government funded residential homes, originating from the Soviet era, provide services for older people with psychiatric problems and other types of disability. Although not every municipality has a residential home for older people, often three or four municipalities organise a joint residential home. Residential provision is provided for older people who do not have children and older residents pay 80% of their pensions to cover the costs. Municipalities also support older people living in their own homes. Once again, if an older person does not have children, the municipality will pay for this home care services (to a maximum of €20/ month). Recent legislation has made each municipality independent so that it is now more difficult for groups of municipalities to provide joint services. Workers for the state run residential homes, known as social 'drivers' and for municipal homes, known as social workers, are covered by the same collective agreement.

In Georgia, the issue of social care is not a popular political issue because people do not want to place older people in institutions. There is limited residential care provided by the government but it is difficult to access. Most social care is provided by family members. For families who are able to pay for care, a nurse or social workers may provide care for an older person. Trade unions are starting to raise awareness of the need for social care services.

Many people in Central and Eastern Europe feel that long term care for older people is a family responsibility and that children should pay if older people are unable to. People in rural areas have least access to LTC. 11% of women and 6% of men are care givers (Österle, 2010). The predicted increase in the older population will place great pressure on existing care arrangements.

## 7.2 Predicting long term care

All national governments are trying to predict or anticipate the demand for long term care in the future. The evidence for predicted high levels of disability is subject to some debate. A recent study of recent trends in the prevalence of disability in 12 OECD countries showed that one group of countries (Denmark, Finland, Italy, Netherlands and the US) showed a reduction in disability prevalence. In Sweden and Japan there was an increase. In other countries (Australia, Canada) there was no change. The problems in predicting disability rates make forecasting long term care needs difficult. This effectively challenges the assumption that with an ageing population disability and morbidity rates increase.

Debates about the demand for long term care for the older population are based on a series of assumptions. With an ageing population, the proportion of the population in the labour force will be reduced unless there are changes in the retirement age, increases in fertility levels and significant increases in migration. Income from taxation will be reduced if present

levels of taxation remain unchanged. There is evidence to show that with new arrangements for long term care, the demand often increases. This has been the experience of both France and Germany.

The accuracy of predicted levels of care also has implications for assessing the costs of care. Within the last five years, there are signs of a growing consensus on the need for governments to play a key role in funding or facilitating the funding of long term care. A recent report by the European Observatory for Health Systems and Health Policy, based in the World Health Organization, on funding of long-term care suggests three possible options:

- 1) A *safety net system* that reduces the size of state and focuses support on only people who are unable to pay for services
- 2) A *universal system* that covers the whole population where co-payments may be used for some services. These may be tax based universal systems or social insurance funded.
- 3) A *Progressive universalism* approach combines universal entitlement with a means-tested element (Fernandez et al, 2009).

A recent article written by three members of the Directorate –General for Economic and Financial Affairs in the European Commission also argues that governments have a key role to play in enabling and ensuring a viable system of long term care (Przywara et al, 2010). This is perhaps an acknowledgment of the demands from citizens that governments (including local governments) take responsibility for finding funding solutions to long-term care provision. These options are being discussed by several national governments. This is an important development at a time when pressures to increase the role of the private sector in health care is increasing and may appear contradictory.

### **7.3 New technology and care services**

In some countries there are attempts to use new technology to provide care services with a more limited provision of labour. In the Nordic region, the use of information communications technology (ICT) to provide alarms for older people living in their own homes are part of assisted housing schemes. Alarm systems may be used by the older person if they are ill or feeling insecure. Private sector provision of alarm systems is present in many countries. New technology can also help older people to monitor their own health, through self testing and monitoring. Care workers have an important role to play in supporting older people to take more control over the management of their conditions. An OECD report (2009) on care for older people found that the use of ICTs to inform new ways of delivering care has been slow to develop. From a trade union perspective, the use of ICTs in care should support the improvement of working conditions and be accompanied with training and appropriate changes in work organisation.

### **7.4 Types of care providers**

Care services for older people are provided by several sectors in Europe. This section sets out the basic types of services provider, highlighting the advantages and disadvantages of each type.

#### Direct public/ state provision

Services for older people are to a varying extent provided directly (or ‘in-house’) by the public sector across Europe. It is provided by workers who are employed by a local authority, health sector or national government. There are several advantages of direct public sector provision including cost control, political accountability and flexibility (e.g., maybe easier to make changes in budget allocation). There tend to be higher rates of unionisation among public sector care workers. Public sector providers are motivated by meeting the needs of users and the pursuit of objectives of health and social policy and not by generating profits. For local authority providers, they are part of a democratic process, which can monitor and evaluate the services being provided.

### Private (for profit) provision

Increasingly services for older people are provided by profit providers who often enter the easiest and/or most lucrative parts of the care sector. These services have often been contracted/ commissioned by the public sector, and so users may not necessarily see any difference or pay more directly for such services. One of the arguments for contracting out services from the public sector is that commissioning can respond more rapidly to changing needs. Disadvantages of private sector provision, for the public sector, include 'cherry-picking' and also that providers may submit contracts that they cannot deliver in the agreed budget. In other countries, the private sector is paid directly by the service user.

The private sector providers, often publicly limited companies, have to work to generate annual dividends for shareholders. Profits are the main goal for private companies. Private providers of care services may also start as small businesses, which can respond to user needs, but may be taken over by larger companies, which will result in management being further away from the services being delivered. In recent years, private equity investors have bought social care companies, as part of long term investments. This has made the companies subject to the investment strategies of private equity funds, which are focused on a high rate of return for the investor rather than the needs of users. In the UK, over two thirds of care homes are owned by the private sector. Some are contracted by local authorities to provide care for individuals. Individuals also pay for care directly. In contrast, in Norway, only about 10% of older people and people with disabilities receiving institutional care are in a non-profit or for-profit institution, although this percentage is higher in urban areas (Christensen, 2010).

### Multinational companies

Multi-national companies are involved in care services in several ways. Many multinational social care companies own a mix of care homes as well as some clinical services, most usually mental health services. Facilities management MNCs are increasingly becoming involved in the delivery of homecare services, for example, ISS, Sodexo. Some companies, not always involved directly in care, provide luxury retirement apartments with a range of services. The services may cover care but also include recreational activities for people on higher incomes.

Companies are also becoming involved in property investment which includes retirement and care homes. Real Estate Investment Trusts (REITs) have been introduced from the United States into Europe as a way of investing in property. They are joint stock companies that obtain income from property, whether through ownership, management, funding, or a combination of these three. REITs are free from corporate tax and pay out high levels of profits. These arrangements have encouraged property companies to invest in a range of different types of property, including care and retirement homes. The disadvantages of these types of investments are similar to that of private sector providers, in that profits motivate the strategies of the companies, rather than the needs of older people.

### Not for profit/ voluntary providers

The not for profit/ voluntary sector plays an important role in the provision of care services for older people. Originally developing services because of an inadequate provision by public or private sectors, the not-for-profit sector has often been influenced by user groups, who not only provide services but also campaign and advocate for services for older people including their rights as users. Not-for-profit companies are increasingly contracted by the public sector to deliver services. In some European countries, charitable organisations, such as the Red Cross and Caritas, are the major providers of care services for older people. Not-for-profit organisations do not necessarily have a tradition of unionised staff not least because they have often depended on volunteers for part of their tasks or labour force (with increased specialisation of services requiring qualified staff the role of volunteers is decreasing; they are also as a rule performing auxiliary tasks) and due to specific labour law for church-run

institutions in Germany. Not-for-profit organisations do not necessarily have better employment relations than profit-making companies.

#### Social enterprise companies

In several countries, for example, United Kingdom and Italy, social enterprises are becoming providers of care services for older people. In other countries, social enterprises provide many different forms of community services, which promote social inclusion. These are considered an alternative to government or municipal provision. In some European countries, social enterprises are legally cooperatives, in other countries, social enterprises are a separate legal entity. Both arrangements take workers out of public sector employment, which has implications for pay, pensions and other terms and conditions. One advantage of a social enterprise organised as a cooperative is that workers may be directly involved in designing and planning the delivery of services, often at a local level.

#### Key points

- Women have longer life expectancy than men and higher income groups have longer levels of life expectancy than lower income groups
- Expenditure on long term care varies from 3.5% GDP to less than 1%
- All countries have at least 10% aged 65+ and this is expected to rise to 25% by 2060
- There are three types of long term care: institutional care (nursing and care homes); home care (nursing and basic living services); informal care.
- Netherlands and Sweden have high levels of formal home care and countries of Central / Eastern Europe have high levels of informal care.
- There has been an expansion in home care and personalisation of care policies giving individuals more control over care delivery
- Funding of long term care is a political issue in many countries
- Increased profit-oriented and sub-contracting of LTC
- There are 3 main types of provider: public sector, private for profit and private not for profit
- Advantages of public sector providers are that they focus on needs of users with some democratic accountability and prioritise the pursuit of objectives of health and social policy
- Disadvantages of private for profit providers are that they have to make dividends for shareholders and investors.

## 7. Organisation of Care services

The health and social care workforce, which includes workers in the long term care sector, is one of the fastest growing economic sectors in Europe, generating about 5% of the total economic output of the European Union. Between 2000 and 2009, there was a net increase of 4.2 million jobs resulting in 21.4 million jobs in this sector (European Commission, 2010). At European level this quantitative growth is very strongly reflected in discourses in the context of ‘steps to modernise social services’. The question remains what this means for the quality of the jobs that currently exist and for newly created jobs.

These jobs are not evenly distributed throughout the European Union. The table below shows how health and social care workers contribute to total national workforces.

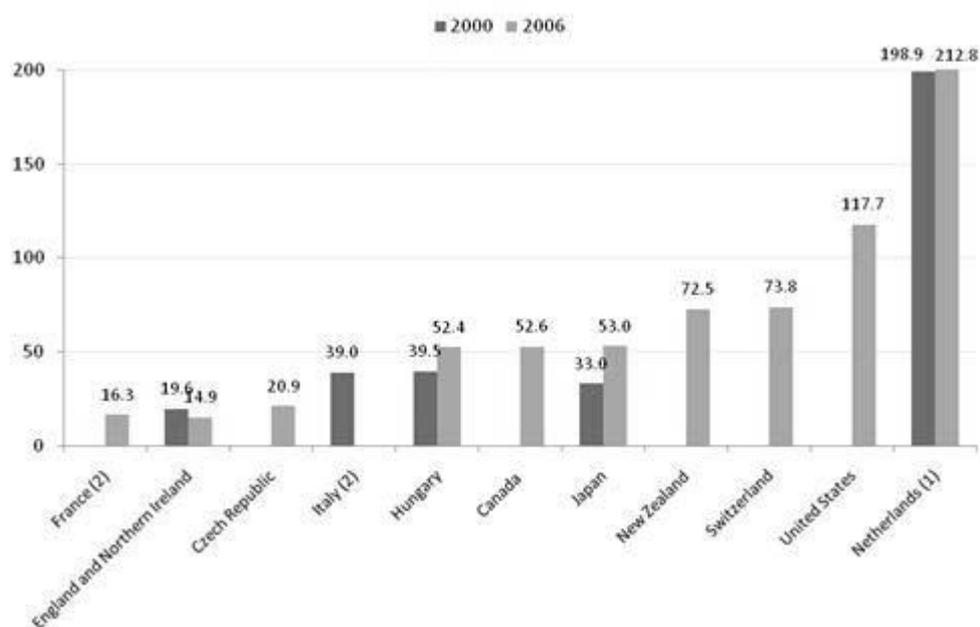
**Table 4: Proportion of total workforce employed in health and social services**

Proportion of total workforce employed in health and social services	Countries
13-18%	Sweden, Denmark, Finland, the Netherlands, Belgium and the UK
9.7-12.9%	France, Germany, Luxembourg, Ireland and Austria
4.4-7.7%	Romania, Poland, Bulgaria, Latvia, Lithuania, Slovakia, Czech Republic

Source: European Commission, 2010: 10-11

For several countries, including the Nordic region, the social care workforce is a significant part of the labour market. The European Commission (2010) reports that social services workforces are being affected by the cuts in public spending that many governments have introduced since 2008. Many care services for older people are publicly funded and how these can be maintained during a period of budget cuts will be a major challenge. The European Commission concludes that “*spending on social services creates jobs and contributes effectively to poverty reduction*” (European Commission, 2010: 20)

Data on care workers for older people is not always available in a standardised way across Europe, although the European Labour Force Survey gives some indications of the size of the care workforce. Individual countries are beginning to collect more detailed data on care workers as care services are recognised as contributing to economic growth. The different government departments that have responsibility for care services for older do not necessarily collect standardised employment statistics that distinguish the different types of care worker (Fujisawa and Colombo, 2009). The figure below shows how the ratio of workers to older people in the population varies by country.

**Figure 3: Ratio of total formal LTC workers per 1000 population aged over 65 years old**


Source: Source: OECD Pilot data collection on long-term care workforce, 2008. cited in Fujisawa and Colombo, 2009: 25

The long term care services workforce has a majority of women workers in all countries, who are predominantly low paid. The workforce is also ageing in many countries as young people are reluctant to enter the sector. As the table below shows, in some countries, at least half the workforce is aged 50 or above. This will place a strain on the supply of labour for long term care services. Recruitment and retention is already difficult because of low pay, the low status of caring as an occupation and poor working conditions. In many European countries, the shortage of local labour has led to the use of migrant labour in care services. This 'brain drain' makes it increasingly difficult to organise high quality, accessible and affordable services in the 'sending countries'.

**Table 5: Percentage of older care services workforce aged 50 +**

Country	% care work force 50+
Czech Republic	d/n
Denmark	50% 40% social workers
Finland	38%
France	36%
Ireland	Majority
Netherlands	30.2% care homes 32.6% homecare
Norway	22.6 50-59 6 60-65 1.5 +65 Total 30% 33%
Romania	50%
Slovak Republic	d/n
Spain	45%
Sweden	33 % municipal sector but slightly lower in private sector Majority SKTF
UK	26% Older workers in local authorities Younger workers in private/not for profit sector
Ukraine	Large %

Source: EPSU survey 2010

Simonazzi (2008) argues that national employment models influence the care labour market, which affect the supply of labour and the dependence on migrant labour. With the majority of European countries developing home care, private care and cash transfers, the creation of a reliable care labour market is becoming an urgent priority. The experience of three countries will be examined as a way of understanding how care labour markets are evolving. Future labour shortages in many sectors of the economy will have an additional negative effect on the supply of care workers for older people.

The recent experiences of four countries – Germany, Italy, Austria and the United Kingdom – are discussed in the context of how demand for care workers has led to the use of migrant workers. However, this is unlikely to be a permanent solution to the demand for care workers in services for older people.

### Germany

In Germany, the allowance can be paid in cash or in kind or as a combination of these two options. However, the value of the in-kind service is about double the value of the cash transfer (Simonazzi, 2008). The in-kind service must be provided by a professional carer who has a contract with a long term care insurer. The cash transfer can be used to pay a family member or an external carer.

In Germany, according to estimates 18% of care workers (in residential and home care) are migrant workers. Many have residence status and contribute to national social insurance funds. 74% of these migrant workers are from the EU with 40% from Eastern and Central European states which have recently entered the EU. Until 2011, workers from new accession states require a permit from the Federal Labour Office. Certain restrictions continue to exist for citizens from Romania and Bulgaria until 2013.

About 115,000 women migrant workers from Eastern Europe work in the care sector as “commuter” migrants, returning to their home countries regularly. They often provide care services which are not covered by long term care insurance or are too expensive. Some of this may be undeclared work, so no taxes and social insurance are paid. Boundaries between legal and illegal work are often unclear (Steffen, 2010). Care workers employed by a private care home may work without a work permit but may be moved back to their home country to do care work and will be replaced by another migrant worker. The care services are operating as businesses free to deliver services in the European Union and across borders (Steffen, 2010). An increasing number of agencies work to recruit nurses and care workers from Eastern and Central Europe. Some may only arrange a placement but other offer more services which cover the whole process of cross border recruitment. These agencies are the only point of contact for families who have complaints or problems with the quality of services.

### Italy/ Austria

In Austria, a long term care allowance was introduced in 1993. This is an unconditional allowance which is not means tested. It can be paid in cash to the dependent person or family, or it can be used to pay the family carers, or hire a service or pay for residential care. The size of the allowance is determined by the level of disability. This is used to pay family members but increasingly employ migrants from Eastern and Central Europe.

40,000 people are estimated to work in care homes for older people, many of whom have been recruited by agencies operating as recruiting centres. Many home carers have to pay 20-30% of their income to these agencies. In 2006, there was an attempt by the Austrian government to legalise these workers and as a short term measure, illegal care workers were entitled to obtain legal employment status on a temporary basis (European Foundation, 2007).

In Italy, a carer allowance was introduced in 1988. This has created a demand for home care workers, which has been met through the temporary migration of workers from neighbouring countries. There are estimated to be 700,000 home care workers, who often live with the person being cared for. Because of their unrecognised status, many migrant workers work for several weeks and then return to their home country on a rotation basis (EU Expert group on gender and employment, 2009). In Italy in 2007 a first national collective agreement to protect the rights of domestic workers and family assistants, notably pay and working hours, was concluded. A salary level is assigned to eight categories of jobs specifying duties and qualifications – which the parties can't go below which is effectively a minimum wage set up by social partners for a specific group of workers. The agreement also stipulates that employment contracts foresee paid time off for vocational training, rules for job sharing and severance pay (Conterno and Portocarrero, 2010).

In Romania and Slovakia, there are higher numbers of male carers because women are migrating to work as carers in Italy and Austria (Österle, 2010). This shows the effect of migration flows within Europe that are taking care workers from low income countries away from their own personal care responsibilities in order to take higher paid care jobs in other European countries.

The entry of Central and Eastern European countries into the European Union has had an impact on where migrant care workers search for jobs. When migration into the EU was illegal, migrant workers moved to nearby countries, such as Germany, Austria and Italy but with legal rights to work in many more European countries, more migrant workers are moving into Northern Europe.

#### United Kingdom

The UK has experienced problems in with the supply of care workers in both institutional and home care. Between 2003 and 2006, over 5,000 work permits were issued for senior care workers (Home Office, 2008). In 2007, the Home Office decided that these posts should no longer qualify as skilled and so would not be eligible for a work permit unless they required formal qualifications at NVQ Level 3 and were paid at least £7.02 per hour. The number of work permits issues for senior care workers in 2007 dropped to 1,005 (Cangiano et al, 2009).

Most care migrant labour had entered through non-labour migration arrangements, for example, for family union, to study, holiday or for protection as a refugee. Tightening of rules for study and for holiday entry is likely to reduce this source of care workers.

Congiano et al (2009) estimate that 135,000 foreign born care workers were working in the UK in the last quarter of 2008 but consider that there are likely to be more. Migrant care workers made up 18 per cent of the care labour force. This proportion of migrant care workers has increased from 8 % in 1998. The majority of migrant care workers came from Eastern Europe, particularly Poland, and sub-Saharan Africa - Zimbabwe and Nigeria. Previously the majority of migrants were from Ireland, Germany and Jamaica (Cangiano et al, 2009). Unusually for the care sector, 35% of migrant care workers were men, which is higher than the proportion of men working as care workers (13%). The majority of migrant care workers are in London and South East, in private sector employment. Longer term migrant care workers are more likely to be working in the public sector.

35% of the nursing workforce working with older people, are migrant nurses, which is higher than the proportion of foreign born nurses in the overall nursing workforce. They are predominantly working in nursing homes in the independent/ private sector (Ball and Pike 2007a in Cangiano et al, 2009). The number of migrant nurses entering the UK has declined in the last decade.

These three profiles of the use of migrant workers in the care sector show that although the proportion of migrant care workers is relatively high in Austria, Italy and the United Kingdom, this is not a stable situation. Changes in national immigration policies can restrict the number

of migrant workers relatively quickly. The employment rights that workers from Eastern and Central Europe gain on entry to the EU, have led workers to move to more Northern European countries, rather than neighbouring countries in Europe. Polish workers in the period immediately after EU entry moved to the UK and other Northern European countries. However, with the recession, there has been a move back to Poland. New migrants from Latin America or Africa are beginning to replace some groups of European migrant workers.

## 7.1 Care workers

With an ageing population and ageing workforce, the demand for care workers will increase. In many countries, young people are reluctant to enter care work as a career because of its low status and poor rates of pay. Maintaining a highly skilled care labour force will be a challenge for almost all governments in future. How shortages of labour are addressed is an issue which trade unions have to continue to campaign on. In the context of the European-level sectoral social dialogue in the hospital and health care sector social partners, represented by HOSPEEM and EPSU, in December 2010 agreed on a Framework of Actions on Recruitment and Retention (<http://www.epsu.org/a/7158>). It constitutes an important basis for social partners at European and national levels to develop concrete action to tackle staff shortages and qualification needs now and in the future. They have agreed to develop joint model initiatives, supported also by the collection of case studies and good practice. They also committed themselves to jointly monitor relevant European legislation and policies and to embark on follow-up action on the implementation of the Code of Conduct on Ethical Cross-border Recruitment and Retention in the Hospital Sector (<http://www.epsu.org/a/3715>). Also governments need to develop employment plans for the elder care sector based on likely predictions of future needs.

In the current period, where funding for public services is being cut, the demand for low paid workers or volunteers to provide care services for older people will increase. In many European countries, there is a long tradition of volunteers providing care services and other forms of social support for older people. As there is a predicted demand for care services, the ways in which these services will be staffed, need to be carefully monitored. Volunteers should complement the work done by employed workers. Efforts should be made to also attract male volunteers.

There are a range of options that could help to increase the supply of care workers.

- Nurses could move from hospital to community services.
- More flexible working time and pension arrangements could encourage care workers to work longer. Wider recruitment and retention policies that address the needs of older workers should also be explored. See EPSU/HOSPEEM Framework of Actions on Recruitment and Retention (<http://www.epsu.org/a/7158>).
- Training programmes that encourage people to enter care work have been introduced in some countries. These need to be developed and designed to encourage groups which are under-represented in the care labour force, to start training.
- Migrant workers should be included in professional development programmes, helping many qualified workers to obtain recognition for their existing qualifications as well as enabling them to access further training.

### Key points

- Health and social care workforce one of the fastest growing economic sectors in Europe
- Majority of care workers are women

- Care workforce is ageing in many countries, raising questions of recruitment and retention
- Use of migrant labour in care services is not a long term solution as immigration policies can affect the movement of workers across Europe
- Governments should develop employment plans to ensure sufficient eldercare workers in future, and promote the encouragement of more men to take up social and elderly care employment

## 8. Working Conditions

This section presents the results of the survey of EPSU affiliates about working conditions, hours of work, collective agreements and the extent of unionisation. Care work covers many different tasks and roles as was discussed in Section 1 (Concept of care). Perhaps one of the most important features of care work is that, as well as physically demanding tasks, such as lifting and turning, there is an essential emotional element which distinguishes it from many low paid jobs. It is difficult to be a care worker without having some type of emotional relationship with clients. This means that the job is not just done within specific working hours but can stay with a care worker during none work time.

Many EPSU respondents, from countries in Continental Europe, the UK and Southern Europe, have provided accounts of care work, which illustrate the nature of care work. In Austria, the *“Working conditions are physically and mentally very stressful”, involving caring for older people with deteriorating health, lifting, carrying, dealing with disorientated people”*. Another source of stress is *“the irregular working hours around the clock (day, night, Sundays and public holidays)”*.

In France, there are similar concerns about erratic hours of work, with weekend work and night work according to the needs of the person being cared for. This also results in few breaks, with difficulties making meals. The uneven working hours can cause stress, fatigue, exhaustion, physical illnesses that cause anxiety and depression. Professional isolation is also reported. In the relatively new residential homes (EHPADs), there are a wide range of concerns about working conditions including: lack of dignity and respect for residents and staff; apparent lack of personnel and facilities; job insecurity and low salaries.

In Italy, the caretaker *“will often live in the same house with the user, and the working time will be much longer than what he or she is paid for but being provided with a home to live is perceived as a form of extra salary and a significant advantage for the caretaker since an average rent would be too high to afford”*. Contractual arrangements are informally agreed with *“working time tailored to individual needs, no social contribution and so no pension, no minimum salary as set in collective agreements (and so no affiliation to unions), and no official assessment of qualifications and skills”*.

In the UK, the role of the home care workers has moved from *“being a low level, domestic function such as cleaning, cooking and shopping, towards a more personal and caring role that often intensive and was previously done by district nurses”*. In private sector: *“a 24/7 work pattern with no additional unsocial hours payments. Zero hours contracts are common. Workers are sometimes told that, where there is no work available, they must either go to other places, have the time deducted or taken as time they owe the employer”*.

Kroger et al (2009) found, in a survey of Nordic care workers, that although all care workers saw *“their work as meaningful and significant”* they also *“experienced it as physically and mentally wearing”*. The *“threat of violence is very high among care workers in all four countries but it is highest in Finland”*. Physical and mental strain of care workers contributed to the intention to leave care work (Kroger et al, 2009).

## 8.1 Terms and conditions

These descriptions of care work give an indication of the quality of the work. The table below sets out weekly working hours as agreed in collective agreements.

**Table 6: Working hours**

Continental Europe	Collective Agreement	Working hours and comments
Austria	YES	38-40 hours/ week CA covers monthly income, allowances, bonuses and allowances and hours of work
France	YES	CFDT social health signed May 21, 2010 collective agreement Branch home help. Birth of the collective agreement assistance, guidance, care and home care. More than 300,000 employees covered.
Germany	YES	
Netherlands	Older care services sector workers covered by the Collective agreement for caring homes, homes for the elderly (residential care homes) and home care.	The collective agreement contains provisions on working hours, for example: - The employer makes sure that a shift does not exceed 10 hours per day. - The employee is entitled to have at least 22 free weekends a year - The employee is entitled to at least 11 hours (uninterrupted) of rest per day
Nordic region	Collective Agreement	Working hours Comments
Denmark	Collective agreement covering public, private and NFP sectors	
Finland	Collective agreements cover 100% municipal sector also private sector has collective agreements	Working time is on the average 38.25 hours in private and public sector
Norway	Collective agreements – but agency workers excluded	Working time: by law, required working hours pr week are 40, 38 and 36 hours in the course of 7 days. The collective agreements provide for arrangements whereby the workers are entitled to a lower amount of working hours pr week; 37.5, 35 and 33.6 hours (Norwegian Nurses Association) In municipalities, widespread use of part time positions with 4 in 10 employees have agreed working week of between 1 and 19 hours/week (NUPGE Norway). Traditionally rosters/turns or periods of duty for female and male dominated sectors have been different in terms of hours and payment. As of January 2010, Norway introduced a new law whereby the terms and arrangements are now comparable
Sweden	Collective agreement for care workers except homecare	Working hours are 37 or 38.25 hours per week for workers who work in elderly care, regular schedule, excluding the night. The only work at night is working 36.33 hours per week. Weekend work is common, in recent times the number of work trips has increased. Usually there is a special night and other personnel working days varied evening

		(two shifts)
Country	Type of collective agreement	Working hours and comments
Ireland	National agreement – broken down since financial crisis	The standard working week is 39 hours. Health professionals and administrative staff work a 35 hour week. Nurses have recently succeeded in getting agreement on a reduction to 37.5 hours. Outside of direct state employment 39 hours would be the norm.
UK	National agreement Home care workers – national and local Health care workers – national	Care workers work 37.5 contractual hours per week. Working time - home care workers - has moved from hours that were contractually fixed and concentrated on daytime periods towards a need to provide a fully flexible 24-hour care service, resulting in enormous changes to home carers' contracts and patterns of work. Most local authorities appear to operate rotas or shift patterns between 7am and 11pm and sometimes with on-call or night shifts. Home carers often experience disruption to their home lives created by these shift patterns.

**Table 7: Types of contract**

Country	Part time	Full time	Fixed-term contracts	Agency workers	Self employed
Austria					
Czech Republic		Majority		Infrequent use	
Denmark	0.25 to 0.33	Majority	Few	few	few
Finland	11.9%	88.1%	19.9%	6.1% hourly	1-2%
France	Majority in home care services	Majority in residential care homes			
Germany	Majority home care				
Ireland		Majority	Majority not in Health Service Executive	Majority in settings where recruitment difficult e.g private nursing homes	
Netherlands 2008	5.6%	85.2%	is 5.6%		3.9
Norway	40% 1-19 hours/week	60%			
Romania	Few	Majority		few	Few
Slovak Republic		Majority		few	Few
Sweden	50%	63% municipal healthcare			
UK					
Ukraine	On request	Majority			

The majority of contracts are full time although there are some countries, such as Norway and Sweden that have between 40% and 50% part time contracts. Care workers for older

people in the public sector are likely to be covered by a collective agreement, with the exception of Ireland, where all workers have taken a 15% pay cut and national collective arrangements have broken down. Workers in the private sector are covered by a collective agreement in the Netherlands and Nordic countries. Agency workers, self employed and short term contracts are most likely to be found in the private or not for profit sectors. As there is a move from public to private provision, these worsened contractual arrangements are expected to affect an increasing number of care workers.

Levels of unionisation vary from country to country. There is no clear relationship between coverage by a collective agreement and the level of unionisation, although the Nordic countries have high levels of unionisation and often 100% coverage by a collective agreement in the public sector. The Netherlands, with 100% collective agreements in both public and private sectors has a much lower level of unionisation in the public, private and not for profit sectors. Countries in Central and Eastern Europe have much lower levels of unionisation.

**Table 8: Level of unionisation and collective agreement coverage**

Country	Level of unionisation Public sector	Level of unionisation Private sector	% covered by collective agreement Public sector	% covered by collective agreement Private sector
<b>Czech Republic</b>	11% overall but 36% where TU active	No TUs in private/ not for profit sectors	31%	0
<b>Denmark</b>	90%		100%	100%
<b>Finland</b>	80%	80%	100%	100%
<b>France</b>		8% private/ 10% not for profit		
<b>Germany</b>				
<b>Ireland</b>	80% -public sector	Lower than 80%	National agreement broken down since economic/ fiscal crisis	
<b>Netherlands (2008)</b>	13.6%		100%	100%
<b>Norway</b>	100%	Difficult to assess	100%	100%
<b>Romania</b>	60%	20%	100%	0
<b>Slovak Republic</b>	25%	0	Law on public service pay	
<b>Sweden</b>	70%	70% same Smaller companies lower rates	95% but not home care or LOV Free choice	Majority but lower in small companies
<b>UK</b>	30% overall but higher in public sector			
<b>Ukraine</b>	80%	Low		

Source: EPSU survey 2010

## 8.2 Implications for trade union organising

The provision of care services for older people is a labour intensive activity. Care workers are employed by public, private and not for profit employers. There is a growing trend for greater provision by private and not for profit providers. The survey of collective bargaining agreements across Europe shows that, with some country exceptions, the coverage of care sector workers is weakest in the private and not for profit sectors. This provides the first challenge for trade unions.

The second emerging issue which will inform organising in the future is the growth of home care workers. There is a growing demand for care to be delivered in people's homes. The financing of care through personalised budgets is contributing to an expansion of individual home care workers who are either self-employed or contracted directly by an older people receiving a care allowance. The expansion of workers who are not employed directly by a large employer makes negotiating collective agreements difficult for trade unions.

Trade unions will have to explore different approaches to organising a fragmented workforce at local and national levels, particularly organising part-time women workers.

Some recent reports on organising fragmented workforces highlight the following points:

- Focus on common work-life experiences;
- Address priorities wider than wages and working conditions
- Use a 'whole person' approach;
- Take age, culture, class into consideration;
- Flexibility in relation to meetings – different times, different places and sometimes on an individual basis;
- Develop non-hierarchical structures
- Use social media as an additional tool for organising but it should not take the place of face to face contact.

Sources: Whitefield, Alvarez, Emrani, 2009; Firestein, King and Quan, 2010; Hill, 2005

### Key points

- Care work covers physically and emotional elements
- Care workers in the public sector are most likely to be covered by a collective agreement although a few countries have collective agreements covering both public and private sectors
- Agency workers, self employed and short terms contracts are most often found in the private and not for profit sector
- Increase in private and not for profit provision and likely worsened contractual arrangements
- Trade unions face two organising challenges: increased movement of care workers into private/ not for profit sectors and increase in home care workers.

## 9. Training and Qualifications

As discussed in the labour market section, recruitment and retention of long term care workers are major problems in many countries. There have been some significant changes in the provision of training for long term care workers, which have been influenced by developments at European Union level as well as a recognition that improved training, will help to ensure higher rates of retention and recruitment.

At EU level, legislation and directives on the promotion of vocational training and the free movement of workers have had an impact on the provision of training for long term care workers. Directive 2005/36 covers the mutual recognition of qualifications. For the hospital/health care and social services sector the first system of automatic recognition obviously plays a key role. Up to now seven professions fall under this category, amongst them nurses, midwives, doctors, dentists and pharmacists. It establishes common minimum qualification requirements. Its implementation ensures a good standard of training for nurses, by establishing what constitutes a minimum general education, how much theory and practice the bachelor degree should contain and the number of hours of study and subjects to be studied. The directive ensures a European understanding and quality of nursing and helps to ensure good nursing education and practice. It also contributes to occupational mobility from one country to another in Europe (NNA). A quarter of the 200.000 persons that moved under the Directive are professionals from the health care sector. A fifth of the cases submitted in recent years to SOLVIT concerns the cross-border recognition of professional qualifications. SOLVIT is the on-line problem solving network in which EU Member States work together to solve without legal proceedings problems caused by the misapplication of Internal Market law by public authorities ([http://ec.europa.eu/solvit/site/index\\_en.htm](http://ec.europa.eu/solvit/site/index_en.htm)).

The European Commission is currently evaluating the implementation of this directive and a report will be completed on the status of implementation in all member states and EEA states by 2012. It will elaborate a Green Paper in 2011 and a revision of the Directive on Professional Qualifications in 2012. The evaluation is an evidence-based assessment of how well legislation has been achieving its objectives and whether the objectives of such legislation are still pertinent in the light of potentially changing needs. The European Commission has referred 24 member states to the European Court of Justice over non-implementation of this directive (NNA). As of early 2011 all member states have (formally) implemented the directive. A fuller implementation of Directive 2005/36 would allow qualifications of some migrant care workers to be recognised.

**Table 9: Professional training required to work in social care, by country**

	<b>Professional training</b>	<b>Additional measures</b>
Denmark	Nurses – 3.5 years higher education BA Social workers - 3 years higher education BA Social educators 3.5 years higher education BA Social and health service (SHS) helpers – 1 year 2 months training – further education – after training a SHS worker can apply to train as nurse or social worker	Social and health service helper training introduced in 1991. Recent reforms changed training at basic level to strengthen possibilities to continue education to other professions.
Finland	Health and social care qualifications set out in legislation, which cover nurses and practical nurses working in older people care services An additional qualification ‘ <i>Specialist qualification in care for the elderly</i> ’ has been introduced	Practice of licensed occupations and professions requires a license or notification and entry onto register run by licensing authority, Valvira.

France	National qualification introduced <i>Diplome d'Etat d'auxilliare de vie sociale</i> (DEAVS) 500 hours theory 560 hours practical 17 hours personal tutoring	
Germany	Nation-wide Code of Care for the Elderly (2003) - not well enforced	Retraining scheme by Federal Agency of Employment –people trained and retrained as carers of older people.
Greece	Social work training upgraded to degree level Technological education institutions forced to upgrade their training	Initiative to train unemployed graduates in caring professional through short term vocational training
Ireland	Nurses trained to primary degree level since 2007. All new entrants to profession must have a degree or equivalent Health care assistants and home helps are trained using in-house programmes that award nationally recognised certificates – but are not mandatory.	Health and Social Care Professionals Council set up to provide system of statutory registration for wide range of groups, e.g social workers.
Italy		Family Counter Project – matched migrant workers and families needing care – and provides training
Netherlands	Care work assistant – no training  Care work/ social care work helper – vocational training level 2  Care worker - / social care worker - vocational training levels 2 and 3  Social care workers – higher education – 4 year course	Professions Individual Health Care register includes doctors, pharmacists...midwives and nurses. Only those on the register can practice and government-registered training is needed for entry on the register. Since 2009, nurses and midwives have to show knowledge/ skills every 5 years.
Norway	Bachelor Degree in Nursing contains theory about older people and part of clinical practice is in nursing homes and community health care.	
Spain	Home assistants and carers in institutional settings – no qualifications Home help workers and family workers/ older people residential care workers - occupational training (for either unemployed workers or employed carers). Not possible to access higher level technician training	In public sector, the Agreement for Continuing Education in Public Administration and in the Private sector – National agreement for Continuing development have been agreed
Sweden	Auxiliary nurse, health support worker and nursing assistant / personal assistant - 3 years Upper Secondary School health and caring  Family care providers (employed by municipality to provide care – no special education	
UK	New 3 year degree programme in social work through partnerships colleges/ employers  National Minimum Standard NVQ2 recently abolished by Care Quality Council (CQC) so a minimum training is watching a video and shadowing a colleague for a day  National Skills Academy for Social Care set up in 2009 to provide for workers in small/ medium size enterprises	Focus on competency based training rather than upgrading of basic or initial skills National occupational standards database – what expected of job role and benchmarks for qualifications Registration of social workers/ social care managers and in future social care workers but currently delayed

**Sources:** Employment in Social Care in Europe – European Foundation  
Moss et al, 2004 and 2010 EPSU survey results

**Table 10: Professional training in Eastern and Central Europe, by country**

Country	Training or accreditation	Additional comments
Czech Republic		Czech Catholic Charity (voluntary & social care provider) runs a course at the Faculty of Humanities in Charles University, Prague 130 students enrolled, 20 graduate/ year
Poland	Until 2001, no qualification needed to work with home care/ residential care. Decree ordered new occupations - home care worker, residential worker – all required qualifications	
Lithuania	Accreditation of training	Ministry of Social Security & Labour – training for social work employees Social care workers could qualify for training and certification but unless continue to train, then can only work as social care assistant.
Slovenia		Social Chamber of Slovenia – training for family assistants
Romania	Poorly managed system of accreditation for social workers and care providers Training at post-high school for older people care workers Auxiliary workers have a base training and follow qualification courses at the workplace	<i>Pro Vocatie</i> programme of training
Hungary	Social Act (1993) set out recognised qualifications Secondary degree - 4 years study in a vocational secondary school – required for a social care worker, nurse and care worker Care workers who work with children, adults, elderly, work full time and have necessary qualification	From 2000, care workers to register on National Registry of Care workers Relevant regulations passed by Ministry of Social & Family Affairs National registry for care workers – compulsory registration, on-going training and pass examination in social services issues. Legislation had been in place and qualifications for care workers but no clear idea of career pathways. Register enables monitoring of who providing care, numbers and fulfilment of training requirements

Sources: Employment in Social Care in Europe – European Foundation Moss et al, 2004 and 2010 EPSU survey results

Several countries have introduced new systems of training for care workers, which are contributing to a gradual process of professionalisation (Moss et al, 2004). In several countries, there are existing systems of training for long term care workers. There are still some countries where home care workers or personal assistants have minimal levels of training and no recognised qualifications. The expansion of home care work, makes the lack of clarity about training, a serious problem for future recruitment and retention.

As well as raising the level of training required, some countries have set up new systems of registration. Although registration is most often required for health care professional groups, such as nurses, midwives and pharmacists, there have been some efforts to create a register for care workers. Maintaining an up-to-date register requires resources as does the monitoring and evaluation of existing systems of registration. There are several countries which have a system of regulation but limited resources available to monitor its use.

**Table 11: Trade union involvement in training**

Country	Type of involvement
Czech Republic	TUHSSC CR is a part of internal consultation process of comments and consultations on every draft law prepared by the Ministry of Health and the Ministry of Labour and Social Affairs. TUHSSC CR is also authorized to give approvals for some forms of further education (seminars, conferences, training activities) to be listed among the “credited ones” (for which a participant receives “credits” proving his/her participation in LLL).
Denmark	FOA are represented on the Education Committee and other political committees. Trade unions are consulted by the government on any changes in the formal education. They are also involved in developing further training offered by the university colleges.
Finland	Trade unions are actively involved in preparatory and legislative work and consulted by ministries (e.g. Ministry of Social Affairs and Health and Ministry of Education) as well actively involved in implementation and evaluation
Ireland	IMPACT organises and represents many health and social care professions and enjoys cordial relations with the relevant professional bodies often making joint representations on issues to do with training, registration and qualifications.
Netherlands	Abvakabo FNV, together with other unions and employer organizations, is part of the Board of Calibris, which is responsible for accreditation of training companies and the maintenance of the qualification structure for the care sector.
Norway	Establishing teaching nursing homes has been a priority. Establishing and funding of teaching home care service institutions is in the process of being facilitated in all counties/regions
Romania	Romanian Trade Union Federation SANITAS provides financial support for qualification programmes
Slovak Republic	Trade union involved in the legislative process and comments on the proposals
Sweden	Will be represented in the forthcoming National Programme Council for Care - care oriented. In 2011 is already included in the "National Apprenticeship Committee" a testing ground for apprentices. At the local and regional level, there has been Programme Council and lärlingsråd where representatives from the Municipality are included and there are a systematic three-way negotiations between school and work, employers and employees. A collaboration with Gothenburg University gave the opportunity for nurses to read the Health Care and so acquire higher skills. Initially a project, this is now part of a standard degree course. Participation in reference groups and respond to consultations.
UK	UNISON is involved in workforce negotiations and bargaining, mapping workforce roles, participation in workforce remodelling agreements and participating in Workforce partnership strategy boards.
Ukraine	Involvement in the development of workforce qualifications every 2-3 years.

(Source: EPSU survey, 2010)

Trade unions in almost all countries are involved in processes of consultation about training and qualifications. Several unions have places on Advisory Boards and other are actively involved in the development new forms of training and professional development.

There are several examples of good practice. The concept of a health care college has been the product of a successful alliance between the Swedish Association of Local Authorities and Regions (SKL), Municipal Corporate Unions (CPMP) and Healthcare Enterprises (ALMEGA). Steering groups at national, regional and local level work to develop and organise health care colleges. At the local and regional level, it is a trilateral cooperation between education, employers and employees, where employers are in the majority and also hold the chair. The aim is to ensure that training is current and relevant and that students become employable, obtaining internships with trained tutors. VO-colleges provide educational opportunities and validation for both adults and for existing employees. The students sign an agreement with their employers as well as a letter of intent with the University.

In Ireland, the SKILL project, aimed to improve the level of training and qualifications of support staff. Led by the trade unions, it is run on a partnership basis with employers. The funding is 'ring-fenced' and so has been protected from the recent cuts that have decimated budgets in almost every other area.

Key points

- EU level Directive 2005/36 designed to increase the free movement of workers in Europe and facilitate recognition of qualifications
- New systems of training for care workers in some countries
- Levels of training for home care workers often minimal

## 10. New Ways of Working and New Services

There are several types of trade union involvement in new ways of working. Social dialogue, improving quality standards and training are three of the main areas where trade unions have been active.

### Social dialogue

Ireland: As part of the sectoral social dialogue process, staff involvement in service planning started about ten years ago. Organisational changes to the health service delivery system and, more recently, the economic crisis stopped this approach before it had time to really develop.

### Improving quality standards

Netherlands: The collective agreement states that the establishment of a VVAR (*Verzorgende en Verpleegkundige AdviesRaad*), translated: caring and nursing advisory board) at institutional level is recommended. The VVAR is an independent advisory board by and for all nurses and caregivers. The purpose of the VVAR is to monitor and promote quality care within the organisation.

### Training

Norway: NUPGE helped to create a teaching nursing home, the Songdal Farmstead Nursing Home, in 2001, which has become a resource for teaching, research and professional practice. It has helped to provide a setting for ethical reflection of work in municipalities. The teaching nursing home complements other services improvement that NUPGE has been involved which cover: team management; recruitment and retention; user involvement and; health at work

### **New services**

With increasing life expectancy, even though this is still unequal according to sex and class, the implications of leading longer healthier lives means that government, private and not for profit services providers will have to adjust to the increased expectations of older people and greater demands for a wider range of services and support. The concept of 'healthy ageing' has been developed to try and focus on the type of activities that older people would like to do and would find beneficial as they get older. Increasingly, the implications of longer life expectancy are being recognised as requiring a new way of planning and delivering services.

### National framework for high quality services

The Finnish Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities first issued a national framework for high-quality services for older people in 2001, when such frameworks were a new form of informative guidance. The present revised framework incorporates current national strategies in old-age policy, assessments of the earlier framework, the latest research findings and recent changes in the operating environment. The current reform of the municipal and service structure in Finland is having a particularly great impact on services for older people. The Ministry of Social Affairs and Health drafted the new framework jointly with the Association of Finnish Local and Regional Authorities and the National Research and Development Centre for Welfare and Health (STAKES). The framework is designed to help municipalities and cooperation districts to develop their services for older people on a basis of local needs and resources, jointly with the third sector, private-sector service providers, and clients, their relations and other local residents. Municipalities are required to draw up their own old-age strategy to prepare for the demographic change, and integrate it into their municipal budget and budget plan. Implementation of the strategy will be monitored regularly.

The Finnish Constitution requires government to ensure the implementation of fundamental and human rights, including the right to equal treatment and essential care. The new

framework defines the values and ethical principles guiding the provision of services for older people. It also outlines strategies for boosting quality and effectiveness in three dimensions: (1) promoting health and welfare and developing the service structure, (2) staffing levels and staff skills and management, and (3) old-age living and care environments.

The framework sets national quantitative targets for services for older people that municipalities and cooperation districts can use as a basis for fixing their own targets. It underlines the primacy of promoting health and welfare, of giving priority to prevention and support for home living, and of comprehensive assessment of individual needs. The range of available services must be diversified with the addition of advisory and other preventive services, and health, functional capacity and rehabilitation must be supported throughout. The principles behind the staffing levels used are explained, and recommendations are made for minimum levels in 24-hour care. The importance of increasing employees' well-being at work, skills for working with older people and managerial abilities are emphasized. Improving the quality of older people's living and care environments means investing in accessible, safe and pleasant surroundings. The framework includes monitoring indicators for the collection of local and national data on implementation of the main areas covered by the new framework.

#### Healthy ageing

New healthy ageing initiatives draw on several health promotion principles that may support older people to live longer healthy and more active lives. These basic principles are older people as community resources, peer support, increased social interaction, providing access to information, training and education, and supporting physical activity. Some examples are set out below.

#### Older people as community resources

In Italy, a project was set up to use older people as resources for the community rather than seeing them as a burden. Older people have experience, skills, competence, practical and theoretical abilities, history and wisdom and can be a resource for a neighbourhood and town (Swedish National Institute of Public Health, 2006).

The Stirling Healthy Ageing project created a partnership between agencies, WHO and people aged 50 + in Sterling as a way of planning and implementing health and well-being strategies (Swedish National Institute of Public Health, 2006).

#### Peer support

The *Seniorengenossenschaften* initiative, in Germany aims to encourage more independent living among older people. 'Younger' older residents provide care for the very elderly in a system of housing cooperative. When they become older, they receive care themselves. The number of these cooperatives is increasing, in part due to the support of the Ministry for Social Affairs. (European Foundation, 2009)

#### Social interaction.

Creating community day centres for older people from ethnic minority groups help to support more social interaction between older people. (Swedish National Institute of Public Health, 2006).

#### Providing access to information, training and education.

The Dulwich Helpline - Friendly volunteer support for isolated older people – runs computer groups with local schools in term-time. Each group matches a school pupil with a service user for one-to-one learning about computers. Popular themes are emails and the internet, digital photography, or a basic introduction to computers for the first time (Dulwich Helpline, 2010)

New services that meet the changing needs of an ageing population will have to be designed in partnership with older people. Services will have to move away from just having a focus on care to covering a broader range of activities, such as information provision, education,

training or physical activity. The emphasis will have to be on cooperation with older people. This also returns to the wide range of approaches that inform the design of care services, including social pedagogy. The integral part that education plays in child care will have to be replicated in care services for older people. This will impact on the type of training required for care workers.

Key points

- Social dialogue, improving quality standards and training are three ways in which trade unions contribute to new ways of working
- New services will have to be designed with contributions from older people
- A greater recognition of the role of education in maintaining health and wellbeing in older age is needed

## 11. Conclusion

Care work for older people is evolving in many countries but it remains an occupation that has a predominantly low paid, female workforce. Reforms to the system of payments for older care have been adopted by several countries. In other countries, discussions are taking place, with recognition that an adequate system of older care provision is a priority. Some countries are making the transition from a family model of care to a more diverse form of formal and informal care.

The increase in home care, where care is delivered to an individual's home, whether by public, private or not for profit providers or self employed carers, can be seen in the majority of countries. The changes in society which are supporting the demands for more individual personalised care delivered at home are challenging the convention model of institutional care homes, even though these still provide a significant amount of care. However personalisation is also leading to the creation of new types of jobs which are often unregulated and unprotected. One of the major challenges for trade unions will be how to organise and negotiate terms and conditions for these new groups of home or personal assistants.

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## 13. Appendix A: QUESTIONNAIRE RESPONSES

COUNTRY	UNION	Contact details
Austria	GdG-KMSfB	GdG-KMSfB Gewerkschaft der Gemeindebediensteten - Kunst, Medien, Sport, freie Berufe Zentralsekretariat 1090 Wien, Maria-Theresien-Straße 11/7.Stock, Zi. 710 Tel.: +43 1 31316 83691 mailto: <a href="mailto:thomas.kattnig@gdg-kmsfb.at">thomas.kattnig@gdg-kmsfb.at</a> URL: <a href="http://www.gdg-kmsfb.at">http://www.gdg-kmsfb.at</a>
Czech Republic	CMKOS	Ph Dr. Jana Veselá Asistentka pro zahraniční styky Odborový svaz zdravotnictví a sociální péče ČR Koněvova 54 130 00 Praha 3 tel: +420 267 204 321 <a href="mailto:vesela.jana@cmkos.cz">vesela.jana@cmkos.cz</a> <a href="http://osz.cmkos.cz">http://osz.cmkos.cz</a>
Denmark	Danish Nurses Association/ OAO	Kim Øst-Jacobsen R.N. Consultant International Affairs tel. (direct) +45 4695 4141 Mobile: +45 29621543 email: <a href="mailto:koj@dsr.dk">koj@dsr.dk</a> Danish Nurses' Organization Sankt Annæ Plads 30 1250 København K tel.: +45 33 15 15 55 <a href="http://www.dsr.dk">www.dsr.dk</a> <a href="mailto:dsr@dsr.dk">dsr@dsr.dk</a>
Ireland	IMPACT	<i>Elaine Elliott</i> on behalf of Kevin Callinan National Secretary Health & Welfare Division <u>IMPACT</u> Phone: 01 817 1525
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Netherlands	Abvakabo FNV	Salskia Olsthoorn

Norway	Norwegian Nurses Association	Anne Berit Rafoss Special Adviser Norwegian Nurses Organization
Norway	FAGFORBUNDET (NUMGE) Norway	Signe Hananger FAGFORBUNDET (NUMGE) Norway Seksjon helse og sosial Avdelingsleder tlf. 23 06 43 14
Slovak Republic	Slovak trade union of health and social services	Mgr. Slávka KNAPČOKOVÁ medzinárodný úsek a realizácia projektov GSM +421 918 182 706 + 421 2 502 40 298 <a href="mailto:knapcokova@sozzass.sk">knapcokova@sozzass.sk</a>
Spain	FSP-UGT	Pilar Navarro Barrios SECRETARIA FEDERAL SECTOR SALUD, SERVICIOS SOCIOSANITARIOS Y DEPENDENCIA FSP-UGT
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UK	Unison	Marilyn Bailey Assistant National Officer UNISON Local Government & Police and Justice Section 1 Mabledon Place London WC1H 9AJ Tel: 020 7551 1789
Ukraine		T.Nikitina, Chairwoman of the State Employees Union of Ukraine Купи хостинг «Эконом» - получи футболку в подарок <a href="http://www.hostpro.ua">www.hostpro.ua</a>



# The European Federation of Public Service Unions (EPSU)

It is the largest federation of the ETUC and comprises 8 million public service workers from over 250 trade unions; EPSU organises workers in the energy, water and waste sectors, health and social services and local and national administration, in all European countries including in the EU's Eastern Neighborhood. EPSU is the recognized regional organization of Public Services International (PSI).

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**President: Anne-Marie Perret, FGF-FO, France**

**Vice-Presidents: Dave Prentis, UNISON, UK and Tuire Santamäki-Vuori, JHL, Finland, Rosa Pavanelli, FP-CGIL, Italy and Mikhail Kuzmenko, HWURF, Russia**

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- **National and European Administration**
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- **Social and health services**
- **Public utilities**

