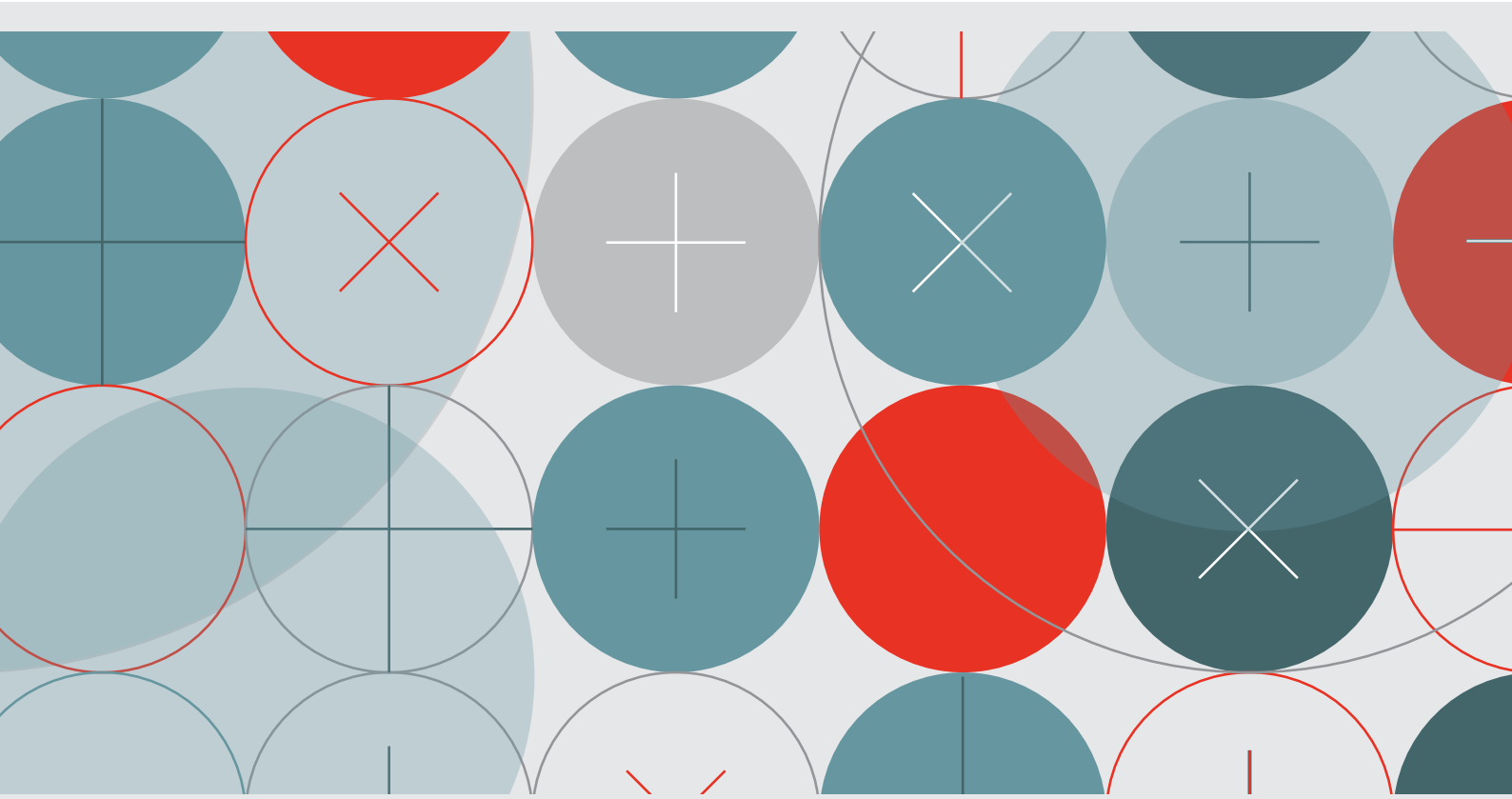
EXPLORATORY REPORT
FOR EPSU HCA NETWORK
GROUP MEMBERS

EPSU
EUROPEAN PUBLIC SERVICE UNION

# REGISTRATION OF HEALTH CARE ASSISTANTS

## AN INVESTIGATION OF BENEFITS AND DRAWBACKS BASED ON EPSU AFFILIATES' EXPERIENCES



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# INTRODUCTION

EPSU commissioned a research project to investigate the benefits of Health Care Assistant (HCA) registration in collaboration with affiliates. This exploratory report considers the situation in five countries, based on contributions provided by Kommunal (Sweden)[1], UNISON (United Kingdom)[2], SIPTU (Ireland)[3], FSS-CCOO (Spain)[4] and FZZPOZIPS (Poland)[5]. The report discusses the contexts where proposed registration schemes for HCAs are being discussed, as well as those where alternative approaches to regulation exist that do not involve registration. General recommendations based on these observations are outlined. Five country case-studies are included in the main body of the report.

1 Interview with Mari Huupponen (Kommunal) - 21 April 2022
2 Interview with Stuart Tuckwood (UNISON) – 12 April 2022
3 Interview with Damian Ginley (SIPTU) – 12 April 2022
4 Interview with Yolanda Gil Alonso (FSS-CCOO) – 27 April 2022
5 Interview with Sylwia Osiadacz (FZZPOZIPS) - 26 August 2022

# DEFINITION

EPSU has adopted a broad definition of Health Care Assistants (HCAs) that involves a 'very wide understanding of the occupation which will comprise workers not performing jobs of other health and social care professionals'.[6] There are significant differences in how HCAs are defined country to country, involving a range of occupational categories with varying levels of formalisation, regulation and integration into professional career structures. Typically, HCAs make up a large proportion of the workforce in social care settings (usually referred to as 'care aides') as well as across many different health care settings.

6 Communication from Adam Rogalewski (EPSU) – 4 August 2022

# PURPOSE OF REGISTRATION

Registration of health professionals is closely linked with the objectives of regulating who can practice a profession, regulating training and qualifications and the setting of standards for patient safety. Where professions are subject to licensing and registration, the attainment of qualifications is not the only consideration, but typically involves a process of examination to determine competence and fitness to practice. This typically involves the legal protection of professional titles under national legislation, so that only persons placed on the registry of a statutory authority are permitted to use the title (usually accompanied by financial penalties or prosecution for misuse of a title).

As a method of regulating health professions, registration is a common piece of regulatory architecture across most of the world. It also has a long history that predates the existence of modern healthcare systems. In Britain, for instance, the modern General Medical Council in Britain was first established as a statutory body in 1858 for the purpose of distinguishing qualified from unqualified practitioners but earlier licensing of doctors by the College of Physicians dates to the 16th century. From the early 20th century, equivalent registration schemes for nurses played a key role in their professionalisation. As the health system evolves, with new occupations and functions, the scope for registration has also expanded with additional professional titles protected through registration.

# REGULATION OF HCAS IN THE CONTEXT OF OTHER HEALTH PROFESSIONS

In most countries, HCAs are excluded from professional registration applied to nurses, doctors and various other health professions. A substantial proportion of the health and social services workforce remains unregulated (or underregulated) despite expansion of registration to new professions. There is no common definition of HCAs, and there is a high amount of inconsistency among even relatively comparable countries in the EU. Although the methods for administering licensing and registration are relatively similar in different national contexts, there is little consistency among countries in terms of the definition and inclusion of various professions that are protected. As states can choose which titles to protect, each has a unique mix of regulated and unregulated professions. EU Member States voluntarily declare regulated professions within the framework of Directive 2005/36/EC on the recognition of professional qualifications;[7] so far 14 member states have done so in relation to the occupational category of 'second-level nurse' – this is a category that only partly corresponds with HCAs. The countries which are assessed by the EU Commission as regulating HCAs are: Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Italy, Latvia, Luxembourg, the Netherlands, Slovakia and Spain. [8]

In the cases of the five countries (Sweden, Spain, Ireland, UK and Poland) examined for this report, there are significant differences in the definition of HCAs, the relevant sectors and settings, and the status of regulation and proposals for registration.

7 https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32005L0036

8 https://op.europa.eu/en/publication-detail/-/publication/1f0bf873-1784-11e8-9253-01aa75ed71a1/language-en

# STATUS OF HEALTH CARE ASSISTANTS AND REGISTRATION PROPOSALS IN FOUR COUNTRIES

**Sweden:** the country is in the process of introducing a registration scheme for 'practical nurses' which is due to be implemented from 1 July 2023. This is a large-scale reform that will protect the professional titles of 180,000 workers across both health care and social care sectors. There are 50,000 practical nurses in health care. This is the second-largest occupation group, comprising 26% of the total health care workforce. In the social care sector, there are 129,000 practical nurses who comprise 70% of the total social care workforce (the remainder being care aides who are not covered by the registration scheme).

**Spain:** there is no mandatory registration scheme for HCAs as applicable to doctors and nurses. However, the occupation of HCA is regulated under health law. In order to practice, all HCAs need a certificate of medium grade professional training. This means that in the context of residential elder care in nursing homes all workers are regulated. Yet, only 1/5 of paid work in Spain's elder care is in nursing home settings - a very extensive workforce is in domiciliary settings, especially live-in care workers, who fall outside these regulations.

**Ireland:** there is currently no registration scheme for HCAs. It is however an issue of current active discussion with a governmental task force reviewing regulations providing an opportunity to advocate for introducing registration. HCAs are already defined as a category within the banded-pay system, comprising the majority

of the eldercare workforce and significant proportion in mental health services. The grade of 'Health Care Assistant' was first established in 2001 and further articulated in 2018. Yet unlike other health professions, HCAs are excluded from certain protections afforded to nurses, including important OHS protections. The introduction of a protected HCA title through registration and regulation would improve the standard of staff and to lift the floor especially in the private sector, helping to standardise the role, the scope of practice, and to control access to employment and assist in workforce planning.

**United Kingdom:** there is significant internal divergence, with the jurisdiction of England behind Scotland, Northern Ireland and Wales as well as the rest of Europe in its regulation of HCAs as well as health workers in general. This relates to workers both within the hospital and social care sectors – but also a number of other health professions, including assistant nurses, who are not covered by mandatory registration. While there are some 1.3 million workers who are registered by three separate statutory authorities, approximately two-thirds of the UK's health and social care workers are not covered by registration requirements. For social care workers in particular, there are minimal barriers to enter the workforce and there is a high proportion of workers with an absence of any qualifications. The UK government is in the process of reviewing the adequacy of regulations, but it has already signalled that it will not consider statutory registration preferring to encourage voluntary schemes instead.

**Poland:** HCAs in Poland are regulated as a profession, and there is a uniform definition that covers all workers employed across all public and private settings in health and social care. There are approximately 70,000 diploma-qualified HCAs (20,000 employed in the health system), with increasing numbers as more workers are trained. HCAs are not subject to a registration scheme in the same sense as doctors and nurses. However, recent reforms have introduced stronger regulation of HCAs, with permission to practice contingent on mandatory qualifications and passing state-administered examinations.

# ISSUES CONCERNING HCA REGISTRATION

## Registration and lifting the floor on wages and conditions

Introduction of a mandatory register for HCAs is an important goal to raise training and qualifications, standardise roles, define a professional category and establish permanent career paths for a large number of workers who are at the lowest tiers of the health and social care workforce. This can promote a more stable workforce with reduced turnover, build union power and facilitate collective bargaining to raise wages and conditions to levels that are commensurate with other professional categories that are at a similar level. There is however no automatic link between the introduction of registration for HCAs and bargaining outcomes leading to lifting of conditions, wages, security of employment, etc. If registration is introduced poorly, ill-designed or inadequately timed, in the context of budgetary austerity without other measures to invest in the workforce, there are also risks of adverse impacts on HCAs and the sector as a whole. Such risks include imposing additional costs on low paid workers without reward, accelerating early retirements of experienced staff, and creating bureaucratic barriers that discourage rather than encourage recruitment. Registration could also result in increased rather than reduced task-shifting if it is only partially introduced in a part of a sector or sub-sector in a piecemeal manner, not covering the entire HCA workforce, or if employers are permitted to replace newly-registered HCAs with non-registered workers. It is therefore important to pre-empt such outcomes and promote comprehensive registration proposals as a component of a broader strategy linked to regulation, financing and bargaining across the whole of health and social care sectors.

## Institution responsible for registration

In most cases, the licensing and registration of doctors, nurses and certain other health professions is administered by a professional association (like a college of

physicians or college of nurses). These are typically government-approved authorities with a statutory role under law, yet independent from the state. In some cases, however, administration of registration and licensing is administered directly by government agencies, fulfilling a similar function. The regulatory arrangements vary between countries, and an important consideration for any proposed HCA registration plan is the specific national context and what is the appropriate authority. This could be an existing professional association, for example a nursing college, or a new independent authority that could be created specifically for the purpose of HCAs. Alternatively, registration could be directly administered by the ministry of health or other government department.

## Adequacy of planning and implementation

Introducing HCA registration is more than a bureaucratic reform in regulatory arrangements. As the case in Sweden shows, the plan for introducing registration for the country's 180,000 practical nurses is a very complex task involving a large proportion of workers with different educational backgrounds and experience levels who will need to be validated. The scale of this undertaking needs to be matched with appropriate planning, resourcing and timeframes, as well targeted initiatives to support workers during the transition, including the provision of education. The implementation period in Sweden was originally proposed to be 5 years, however, it has been extended to 10 years when the challenges become evident. This requires substantial administration, and the Swedish Socialstyrelsen will have to employ a large number of staff to administer the process. The main bottleneck is the need for structured assessment processes to recognise existing skills and competence, establish where this might need to be supplemented with additional courses, and allow time to undertake additional learning where this is assessed to be needed. The EU Council Recommendation on validation of non-formal and informal learning 2012/C 398/01 offers some guidance in this respect, with the validation described in four separate steps: identification, documentation, assessment and recognition (certification).[9]

## Costs of the registration fee

In all discussions concerning HCA registration, the issue of a fee was raised as an important consideration and a key potential barrier, given that such a fee could potentially be levied on a low-waged workforce. The fee structure for registration of doctors and nurses is generally high, and the concern is that the same approach introduced to HCAs will encourage exit from the sector. This is likely to lead to clashes with government proposals that are likely to push for registration as a

9 http://csdle.lex.unict.it/Archive/LW/EU%20social%20law/EU%20non-binding%20acts/Recommendations/20121228-103945_12_398_Council_Rec_enpdf.pdf

'cost neutral' budgeting measure, ie. for the scheme to be self-funded from fees. In Sweden, Kommunal supports the introduction of a fee but is pushing for it to be reduced to between €30 and €50. In Ireland, where the fee is expected to be around €100, SIPTU is called for the fee to be paid by the employer.

## International transferability

A protracted discussion took place on the EU level on the feasibility of establishing a Common Training Framework for HCAs under the Professional Qualifications Directive.[10] Following several studies, the most recent European Commission report from 2018 provides an important insight into the high degree of variation across the EU in terms of the definition of HCAs and looks comparatively at the status of regulation, training standards and competencies. What emerges from this is a sense of the difficulty to develop any concrete proposal for how the HCA role could be standardised across the EU. In particular, it would be undesirable for countries that have higher standards to see them reduced to the common standard, whereas this presents a high threshold for countries that are not regulating HCAs to attain. Nonetheless, in terms of Directive 2005/36/EC, the HCA profession is entered into the regulated profession database (the category used is "second-level nurse") in 14 countries. The introduction of registration in Sweden for practical nurses will soon expand this number to 15. Although discussion of the CTF has for now stalled, it is likely that if HCA registration is introduced in more countries, the discussion could be revived.

10 https://op.europa.eu/en/publication-detail/-/publication/1f0bf873-1784-11e8-9253-01aa75ed71a1/language-en

# RECOMMENDATIONS

- Registration of HCAs should be pursued in a way that is aligned with broader long-term strategies aimed at strengthening the health and social service sectors. The goal of lifting the floor for both the health and social services workforces is contingent on investment into the workforce.

- Planning for the introduction of professional registration for HCAs is a complex undertaking. To be successful, the introduction of registration for HCAs requires sensitivity to the needs of the workforce, to foresee potential adverse impacts. The inclusion of HCAs into registration schemes is a greater challenge than most other professions. This is in large part due to the diversity of the workforce, unevenness of educational backgrounds, and in many instances a lack of formal qualifications. For this reason, validation processes need to be well-designed to take into account experiences, competencies and recognise prior learning, supplemented with access to appropriate training where this is needed. For this reason, it is important that the bureaucratic processes are accessible, transparent and adequately resourced, allowing sufficient time frames for transition to take place.

- Trade unions that represent HCAs are uniquely placed to advise on the appropriate planning, development and implementation of HCA registration schemes. It is crucial for unions to be consulted at every stage, including development, timing, implementation, and review.

- Depending on the national context, there may exist appropriate authorities which are responsible for registration of other professions that could expand their function to HCAs. However, where an obvious institutional arrangement does not already exist, unions need to have a clear position on the question of whether a new authority is needed, whether registration of HCAs should be undertaken through an independent statutory authority or directly through a

government agency, etc. Having influence on these considerations is important for the role of unions in shaping regulatory arrangements and their practical administration.

- There are risks of certain adverse impacts which can be predicted arising from the introduction of registration schemes for HCAs. They could arise for instance due to increasing barriers to work, accelerating early retirement of experienced workers, and increasing turnover. Whereas some of this disruption may be expected as a short-term disruption, there is also a potential that greater task-shifting could occur if registration schemes are poorly designed and not matched with adequate investment into the workforce. To counter these risks, it is important to ensure good planning of HCA registration, maximum coverage, and ensure that regulatory reforms occur in conjunction with adequate investment into the workforce.

- The introduction of a registration fee can present a significant barrier and should be either waived entirely or set at an appropriate level to ensure that low-paid workers are not subjected to an additional tax on their labour. Given these considerations, it is important for the registration to be understood as an investment into the workforce that may require additional budgetary resources. A fee could be levied on employers rather than workers or be compensated with a wage increase following the registration process. In addition to the direct costs of any potential registration fees, it is equally important that workers receive financial support for any education and training they might be expected to undertake as a consequence of registration.

# CASE STUDIES

## Methodology

To understand the situation in respective countries in regard to registration and the position of unions on the issue, semi-structured interviews were conducted with representatives of five EPSU affiliate unions: SIPTU (Ireland), Unison (UK), Kommunal (Sweden), FSS-CCOO (Spain) and FZZPOZIPS (Poland).

The following questions were used as a guide:

- The definition of HCAs varies across Europe. Which parts of the health workforce are included in the HCA category in your country? Does it encompass workers in all settings, eg. hospitals, community health, residential aged care, homecare?
- What are the current training or qualification requirements for the employment of HCAs?
- Is there already a quasi-registration process in place, eg. for the purpose of COVID-19 vaccinations?
- What are some of the major benefits of registration of HCAs – do you see them furthering recognition and professionalisation?
- How would a registration scheme work in practice? Would it function as a licensing scheme to create minimum training and education, and thus a condition of entry to the workforce? What institution would be responsible for registration (eg. Ministry of Health, Nursing Council or other professional body, employer)?

- What are some of the potential problems with a registration scheme? Are there any categories of workers that risk being marginalised as a consequence?

- What kind of barriers exist to registration? Are they purely political, or are there also practical and/or cost barriers?

- Are any employers supporting registration/professionalisation of HCAs?

- Issue of a common-training framework (CTF). At the European level, stronger regulation/registration could be achieved through a common training framework for HCAs. Should there be a common European-level framework of registration, to allow transferability between countries? A feasibility study was conducted into this – what is your perspective on whether this would be possible or desirable, or not? Can the issue of registration be ringfenced from setting minimum standards for training requirements?

Interview responses were supplemented with written materials obtained from interviewees and desk research.

## Sweden

Sweden is in the process of introducing a registration scheme for practical nurses, with the aim of improving quality and safety in the sector. The reform involves legislative changes to introduce a protected professional title for practical nurses. It is due to be implemented from 1 July 2023, and will impose restrictions on who can use the title by establishing requirements to practice that are conditional on evidence of a professional's competence and suitability. The reform will establish practical nurses as a regulated profession within the meaning of Directive 2005/36/EC on the recognition of professional qualifications. Significantly, it does not extend to care aides, who are currently a minority of the workforce in elder care. However, there is already an official norm for care aide education that consists of 50% of the requirements for personal nurses. As the next step, Kommunal is campaigning for regulation of care aides.

## Definition of HCAs and the composition of the workforce

The HCA category in Sweden includes qualified practical nurses ("undersköterskor") as well as care aides ("vårdbiträden") who mostly have no formal qualifications and training.

Practical nurses are the largest professional group in Sweden. There are 180,000

practical nurses in total,[11] with approximately 129,000 employed in elder care. Traditionally, they have comprised approximately 70% of the elder care workforce. Practical nurses are also employed in disability care, a sector with poor regulation and huge variation. In health care settings, 50,000 practical nurses are employed – they are the second-largest occupation group comprising 26% of the workforce, thus forming a significant part of the workforce employed at the lowest skill level in patient care.

The competencies and skill level of practical nurses can be compared to some male-dominated professions such as car mechanics, however the salaries are much lower. Practical nurses have varying backgrounds of education, and many workers have worked in the profession for a long time.

The definition of the 'care aide' category is contested. One in five care workers in care homes lack formal education, 4 in 10 care workers lack practical nurse education.[12] For a long time Kommunal had the policy that the practical nurse occupation should be the minimum – however, an agreement was reached in 2017 with SALAR, the main employer federation, to accept the category of care aides on the condition of standardisation of education for all care aides. In the absence of national standards, employers have an incentive to employ staff with lower qualifications.

There is pressure from employers, especially in homecare, to increasingly employ unqualified workers. Kommunal however defines care aides as an occupation, with the position that there should be no unqualified workers in elder care. Although standards of education for care assistant exist for 50% of practical nurses, employers do not yet always require it (those standards are required for assistant nurses to progress in their work career).

## Registration and its implications

Under the incoming reform, the introduction of professional regulation of practical nurses is conceived as a voluntary one, in the sense of each worker applying individually to be covered by the protected title. While failing to do so will not restrict work, the reform will establish an offense punishable by a fine in cases of intentional, unauthorised use of the protected professional title.

A new nursing and care education diploma was established recently, for which the first graduates are expected in 2022. The introduction of a protected profes-

11 https://data.riksdagen.se/fil/71581FB4-6C40-42A8-B2E6-A534544A266C
12 http://library.fes.de/pdf-files/bueros/stockholm/17690.pdf

sional title for practical nurses is expected to lead to shortages in the short-term, as not enough staff will have reached the established competence level. However, the transition rules will help to reduce the impact.[13]

Since many workers have varying backgrounds of education, it is expected that a large proportion will need to be validated. This will involve a structured assessment process to recognise existing skills and competence and to establish where this might need to be supplemented with additional courses.[14] It requires considerable planning to carry out a fair process of validation for such a large workforce. Although initially the government proposed a 5-year transition period, this was later extended to 10 years – but with the date of implementation brought forward.

The responsible licensing authority will be Socialstyrelsen – a government agency operating under the Ministry of Health. This is a status that Kommunal wants, as this authority is responsible for training certification. The reform will involve the introduction of a fee for workers, to cover the examination of the application for identification and for the issuing of the certification. The government proposal expects this fee to cover the full costs of the reform, making it cost-neutral. Also, a fee level set at the same rate as specialist nurses has been proposed (approx. €70 Euro).[15] However, these impose a cost on lower paid workers. Although Kommunal is not against a fee in and of itself, it is pushing for this fee to be reduced – to approximately €30-€50.

There is a risk that some workers may lose their professional title as a result of the reform – and that the number of practical nurses may decline as a result. However, the scale of this is difficult to predict. According to the government's inquiry, "This in itself should not be a major problem - as long as there are no staffing regulations or the like that require a certain proportion of assistant nurses in the operation, and as long as the competence of those affected is utilized in an effective manner. The existing competence remains with employees even if they will need to use a different title."[16] The government anticipates a wage increase of about 15% as a consequence of the profession being regulated. However, this is based on research undertaken in 2008 and is seen as dependent on how employers act. When assessing the implications, the government inquiry also finds that 'total wage costs do not necessarily have to increase' as the increased wages of assistant nurses could be complemented with recruitment of other categories of (lower paid) workers.[17] This point highlights a significant concern that a scheme of this nature, one which covers only what is already the most qualified part of the workforce, could have negative implications.

13 https://data.riksdagen.se/fil/71581FB4-6C40-42A8-B2E6-A534544A266C p. 243
14 https://data.riksdagen.se/fil/71581FB4-6C40-42A8-B2E6-A534544A266C
15 https://data.riksdagen.se/fil/71581FB4-6C40-42A8-B2E6-A534544A266C
16 https://data.riksdagen.se/fil/71581FB4-6C40-42A8-B2E6-A534544A266C p. 204
17 https://data.riksdagen.se/fil/71581FB4-6C40-42A8-B2E6-A534544A266C p. 246

To counter any potential negative consequence of registration that could create incentives for employers to employ greater numbers of unqualified care aides, Kommunal's strategy is to create obligations on employers to employ a majority of practical nurses. Recent legislation covering homecare establishes a 'leading carer' role which must always be filled by a practical nurse.

A recent governmental committee also proposed that a similar role should be implemented in elder care homes, which would assist in regulating tasks and setting a standard for practical nurses.[18]

## Comparisons to other systems and implications beyond Sweden

In preparing the policy for the assistant nurse position to become regulated with a protected professional title, the Swedish government compared other Nordic countries, and specifically Denmark and Finland.[19] Sweden is in many ways behind other Nordic countries on the regulation of elder care and the standardisation of HCAs. In Finland the requirement to work in the sector as a practical nurse has been established for a long time. Practical nurses make up 95% of the workforce and are an occupation with greater autonomy. In Denmark, reforms undertaken about 10 years ago were very successful. The education proved very popular and there was a large increase in the status of the profession.

Unlike many other European countries, Sweden does not rely on filling labour shortages by direct recruitment of care workers from abroad and recruitment tends to occur from people already living in Sweden. Recent research however has found a significant occupational status gap between native and non-native workers. The care workforce in Sweden is more ethnically diverse compared to the overall population (24% of employees in the elder care sector were foreign-born compared to 15.5% overall). Foreign-born employees tend to be under-represented as practical nurses, and instead to be over-represented in lower-status positions, with the greatest disparity among care workers from the Global South. The key factor identified in the research is that of education, and specifically Swedish credentials, which are valued more than those obtained elsewhere.[20]

The legislative change involves bringing the practical nurse occupation into the same regulatory framework recognised under EU law, in accordance with Directive 2005/36/EC on the recognition of professional qualifications. Currently in Sweden there are 88 professions with a regulated status, of which 67 are in healthcare (39 are various medical specialties). Regulating the profession of practical nurse will

18 https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2022/06/sou-202241/

19 https://data.riksdagen.se/fil/71581FB4-6C40-42A8-B2E6-A534544A266C

20 https://www.tandfonline.com/doi/full/10.1080/01419870.2020.1734220

have implications for freedom of movement, and it could become easier to source workers from other counties in the EU, subject to additional language requirements. However, "in order for Sweden to be able to set requirements for competence etc. on other EU citizens, the profession must be regulated in this country." [21]

## Spain

The HCA profession, along with all health occupations, are regulated in Spain. Qualifications are currently set at medium-grade training and a certification to practice the profession is administered by the Ministry of Health. The level of qualifications is generally recognised as of a high standard compared to most countries in the EU. However, it is important to note that in regard to the long-term care workforce in Spain, this regulation only extends to nursing home settings, whereas the vast majority of the workforce is employed in private homes. FSS-CCOO has general objections against any proposed reforms to introduce a registration system for HCAs that relies on institutions like nursing colleges. FSS-CCOO only covers workers in public and private hospitals and nursing home settings, not domestic workers employed in private homes.

## Definition of HCAs and the composition of the workforce

The definition of HCA in Spain corresponds to nursing assistants. It consists of only one level which is standardised and covers all people working in both public and private systems in care homes as well as hospitals. HCAs are regulated as a profession under health law. All HCAs have a certificate of medium grade professional training called "expert in auxiliary nursery care". This is a level below that of a university degree, which allows workers to perform the profession in the public or private sector. The duration of the training is 1400 hours and half a year of internship. The main requirement for access to this qualification is to have the Secondary Education Graduate degree or equivalent. Certification gives the right to work in public or private nursing homes and hospitals – and there are provisions for the recognition of prior experience for those working in the sector.

According to research from the International Long Term Care Policy Network, official statistics report that there were 684,949 people working in social care in 2020, of whom only 19.9% were employed in care homes, mostly as nursing assistants, and 13.9% in social services without accommodation. The remainder – 66.3% of the workforce – were employed directly in private households, mostly as domestic workers – one of the highest registered numbers in Europe.[22] The vast

21 https://data.riksdagen.se/fil/71581FB4-6C40-42A8-B2E6-A534544A266C
22 https://ltccovid.org/country/spain/

majority of the workforce in elder care are 'domestic workers' who fall outside the HCA professional category. They not only fall outside the scope of health law regulation but suffer exclusion from basic labour protections. Four out of five domestic workers are migrant women from Latin America and a large proportion – as 40% of the workforce – are undeclared and work on the black market. Recent estimates suggest that the total domestic workforce could be as high as 700,000 people.[23] A February 2022 ruling by the Court of Justice of the European Union found that Spanish legislation excluding domestic workers from unemployment benefits is discriminatory and contrary to EU law.[24]

The On the Corona Frontline report notes that "one of the main obstacles to properly understanding the needs of the sector in Spain is that there is no official register of persons employed in the eldercare sector." Despite official centralisation of information related to human resources since 2014, workforce data continues to be dispersed between different jurisdictions.[25]

## Registration and its implications

Currently, regulation of the HCA profession is administered by the state. It is not mandatory for HCAs to be registered through a professional association like a nursing college. It is however compulsory for all health workers with university degrees – doctors, nurses, pharmacists, opticians, etc. – to be registered with their respective professional associations. It was not compulsory for public employees until 2018, when the supreme court ruled that university degrees in the health sector had to be registered, whether workers were in the public or private sector.

The FSS-CCOO position is that the introduction of a registration scheme for HCAs is undesirable, since the current regulatory system already fulfills this role in Spain of regulating HCAs under law. There are various such professional associations – established since the 1970s – which function as private-like institutions and regulate professional roles. There is significant variability in these associations. For example, fees are not the same across different regions of Spain – different regions set different prices. Introducing mandatory obligations to be registered would mean devolving responsibility from the state to private-like colleges and that workers should be able to decide whether to be associated with these professional associations or not. Responsibilities for issues like legal protection around professional liability should fall under public administration.

Currently, the HCA have a level 2 qualification, while the proposal from CCOO in

23 https://www.france24.com/en/tv-shows/focus/20210615-your-home-is-my-prison-the-precarious-situation-of-domestic-workers-in-spain

24 https://curia.europa.eu/jcms/upload/docs/application/pdf/2022-02/cp220037en.pdf

25 http://library.fes.de/pdf-files/bueros/stockholm/17762.pdf

Spain is that they become level 3. This means that the HCA will no longer have titles on a medium level, but instead high level degrees. The main demands of FSS-CCOO are for this to increase to around 2000 hours of theory and more than half a year of internship, for HCAs to be recognised as having a higher level of qualification and for this to be reflected in a higher level of salary. The union wants to see the creation of a qualification framework and professional classification that corresponds to the advances that have taken place in the healthcare sector.

FSS-CCOO is campaigning to improve working conditions and wages, to increase qualification (linked to improved salary) not only for HCAs but all workers in the health system. The union is in the process of negotiating a state agreement – the 8th renewal of the Dependencia agreement – for all companies in the nursing home sector. Negotiations started in 2018 and have been blocked for a long time over the issue of pay. The sector is fragmented and difficult to organise.

## Comparisons to other systems and implications beyond Spain

The qualification levels of HCAs in Spain are generally high in comparison with other EU countries – workers are better qualified for example than in the UK, and at a similar level to some Nordic countries. This has facilitated the employment of Spanish-qualified HCAs in other countries in the EU. Conversely, the migration of foreign-qualified HCAs into Spain is less common. Despite this, the recruitment in Spain of domestic workers – mostly from outside the EU – is the highest in Europe. This workforce is essential to sustaining the care sector and meeting the needs of elderly citizens, but they are not recognised as HCAs and are unregulated.

## Ireland

Ireland has a defined HCA title, however there is a lack of national regulations. SIPTU has long campaigned for a regulatory framework for HCAs which recognises HCAs 'in their own right,' focused on 'regulation, registration and protection of the title.'

Over the past two decades, the HCA workforce has significantly expanded. They face a lack of recognition, a lack of appropriate pay and career structure, and a lack of professional development opportunities. There is currently a lot of pressure on the HCA workforce especially in homecare, with big difficulties in recruitment and retention.

A governmental task force is currently in the process of looking into the HCA workforce and how to better resource and regulate the sector, looking at issues

such as work permits and conditions of employment. SIPTU is intervening into this process to advocate for improving regulations and introducing registration as part of the measures to lift the floor.

## Definition of HCAs and the composition of the workforce

In Ireland, HCAs relate to persons who operate at the level of mid-range care – above the level of household and below the level of a nurse. There is no specific 'practical nurse' role in Ireland as in many Nordic countries. The grade of 'Health Care Assistant' was first defined in 2001, replacing a number of existing grades. In 2018, a review of the roles and functions of HCAs identified 10 key care functions undertaken by HCAs.

There is a banded pay system for all health workers, and HCAs were initially at pay band 3. Following industrial action by SIPTU, a review saw HCAs moved to a higher band in 2019, with two tiers established. General HCAs in aged care are at pay band 2, whereas HCAs in mental health are at pay band 1.

There has been a big expansion in HCAs and a shift towards medical settings over the past few years, with nursing roles increasingly being replaced by HCAs, and a blurring of roles over time. This is part of a larger task shift process – duties that doctors would have done are being handed to nurses, and tasks that nurses would have done being handed over to the HCAs. Community eldercare now employs predominantly HCAs. Mental health services are an area where the most rapid changes are occurring. There were very few HCAs in mental health settings ten years ago, whereas they comprise between one-third and half of the workforce in 2022.

HCAs were one of the hardest-hit categories of health workers during the pandemic and were used to fill gaps in other areas across the service. A lot of public narratives focused on nurses as the face of the front line, however this is slowly changing as the HCA grade becomes better known amongst the public. HCAs have highlighted challenges in relation to allocation of duties from colleagues in other grades, i.e., where the duties of one grade finish and those of another starts. Sometimes this can create challenges between grades, undermining valuable input and the responsibilities of HCAs as part of the overall team.

## Registration and its implications

SIPTU is campaigning for a protected title and regulatory framework for HCAs to develop the occupation in its own right. This should be done in a way that re-

sponds to future workforce demand for regulated healthcare workers. It should be reinforced by the ongoing raising of standards in practice through quality assurance frameworks and the planned continuous professional development of all HCAs.

CORU, an independent agency operating under the Health and Social Care Professionals Act of 2005, currently regulates a number of allied health professions such as radiographers, optometrists and social workers. This involves setting standards that workers must meet, ensuring relevant educational bodies deliver appropriate qualifications, maintaining a register of professionals who meet the standards, promoting continuing professional development, and conducting fitness to practice hearings into conduct and competence of the registrants.[26]

SIPTU wants to see the independent regulatory institution extend to cover HCAs. Recognising and protecting the HCA title through registration and regulation would help to standardise the role and the scope of practice, control access to employment and assist in workforce planning. The key objectives are to improve the standard of staff and to lift the floor, especially in the private sector.

The union notes that HCAs want to see progression of their own caring practice, but not necessarily into nursing. There is a need to reform HCA education and practice, establishing a standardised education program that allows developing the HCA practice through career development and specialisation through modular-based education. Unless HCA titles are protected, it will continue to be impossible to ensure that those practicing in these roles have the required standard of education. The entry-level qualification is a FETAC level 5 certificate. However, it is somewhat ambiguous especially within the private sector where it is not strictly administered. SIPTU wants to see validation measures that recognise competencies in order to protect experienced staff who are already working within the system.

Registration will be huge, complex and costly. The issue of a fee is a significant consideration, and it is expected it will cost approximately €100 per worker. SIPTU considers that ideally this fee should be paid by the employer.

If minimum standards are applied, there will likely be a significant short-term impact on the supply of workers, however, in the longer term it would provide improved status to HCAs and attract workers to the profession.

26 https://www.coru.ie/about-us/what-is-coru/

## Comparisons to other systems and implications beyond Ireland

According to SIPTU, Ireland has benefited from transposing EU legislation into Irish law. In principle, international agreements such as a CTF setting a floor would be very useful to define the work and the level of qualifications. However, HCAs encompass many different roles and the challenge is that the grade is so different in so many different jurisdictions. Therefore, it is important to implement regulation at the national level rather than expect such a process to deliver.

## United Kingdom

The United Kingdom is an outlier compared to most other European countries in its 'light touch' regulatory approach and lack of registration for large parts of its health and care workforce. This extends to most of the social care sector, as well as various healthcare occupations in support roles, care provision and some delegated clinical tasks. The arguments for the need to protect HCAs and introduce registration therefore apply not only to HCAs but also many other health professions, including Assistant Practitioners, Healthcare Support Workers and Maternity Support Workers.[27] UNISON has been campaigning for the introduction of statutory regulation and registration for all these groups.

## Definition of HCAs and the composition of the workforce

The HCA category in the UK is somewhat ambiguous, as it can be applied to a wide range of occupations in clinical as well as care settings.

UNISON notes that the range of tasks and responsibilities undertaken by HCAs vary greatly and that there is an enormous amount of inconsistency in practice; unregistered workers undertake caring tasks but also increasingly complex clinical tasks are being delegated to them, both in acute hospital settings and in community practice. The trend of task-shifting from registered to unregistered healthcare staff reveals the need to re-evaluate responsibilities and the delegation of care. Yet despite the complexity of demands on healthcare and changes in the sector, there has been almost no evolution in the regulation and governance of their work. Shortages of registered nurses result in unregistered workers practicing with much more autonomy and less supervision than often assumed.

A large proportion of UNISON's membership are unregistered HCAs.

27 UNISON submission, March 2022, Healthcare regulation: deciding when statutory regulation is appropriate

In 2016, UNISON reported that there were 400,000 HCAs employed in the NHS (out of a workforce of approximately 1.4 million), who provided 60% of patient care.[28] In the social care sector, which accounts for 1.6 million workers, ¾ of workers are in direct care roles, with a roughly even split between domiciliary and residential care.[29]

The title of 'healthcare assistant' is a post within the NHS and requires a Level 2 Certificate in Healthcare Support Services. For the social care sector, an equivalent Level 2 Health and Social Care exists yet there is no formal qualification requirement for entry and only 45% of the workforce have a social care qualification of Level 2 or above.[30]

In April 2015, the Care Certificate was introduced to address inconsistencies in training and competencies in the social care workforce, however it is only basic induction into care (the average time to complete is 12 weeks) and there is no mandatory obligation for employers to use it.[31] UNISON has called for the Care Certificate to be expanded to cover technical skills required of care workers and for it to be used as a pre-requisite for future employment of all care workers. It needs to be flexible enough to recognise the variety of skills in different parts of the sector, and to be integrated with continuing professional development so that there is a ladder of qualifications to aid career progression.[32]

## Registration and its implications

Regulated health professions in the UK have their titles protected by law and professionals must be registered to use them. There are three institutions responsible for regulating protected health professions and maintaining registers:

- General Medical Council (GMC): regulates all doctors including GPs and specialists; 348,582 registered
- Nursing and Midwifery Council (NMC): regulates nurses, midwives and nursing associates; 745,000 registered
- Health and Care Professions Council (HCPC): regulates 15 health and care professions including clinical scientists, occupational therapists, paramedics, physiotherapists and radiographers; 295,665 registered

28 https://www.unison.org.uk/content/uploads/2016/09/24064.pdf
29 http://library.fes.de/pdf-files/bueros/stockholm/17715.pdf
30 http://library.fes.de/pdf-files/bueros/stockholm/17715.pdf
31 https://www.theaccessgroup.com/en-gb/blog/hsc-what-is-the-care-certificate/
32 https://www.unison.org.uk/content/uploads/2020/06/A-UNISON-Vision-for-Social-Care-June-2020.pdf

Registration of HCAs in the UK was a key recommendation of the Francis Report of 2013, an inquiry of what led to poor standards of care at the Mid Staffordshire NHS Foundation Trust.[33] The UK government has, however, rejected proposals to extend regulation to HCAs and other healthcare occupations; its most recent position is not to protect occupations through statutory regulation but to instead encourage voluntary registration schemes.[34] In regard to social care, the regulation that exists is through regulating providers, not individual workers – with oversight from the Care Quality Commission – and no standard qualification framework. There are variations across the four countries of the UK. In recent years, Scotland, Northern Ireland and Wales have introduced a level of compulsory registration for some social care workers (but not all HCAs), with England only rejecting it altogether.

UNISON is supportive of the introduction of a registration scheme for HCAs, and in March 2022 articulated the benefits as part of its response to a government review into healthcare regulation. The union, however, does not have a position on the specific form that a registration scheme for HCAs should take, and argues that it is not up to them to determine this. The NMC or the HCPC are both institutions that could potentially administer registration.

Some industry lobbies and non-union social care industry associations, including Home Care Insight and the National Association of Care & Support Workers, have also supported and campaigned for the introduction of registration for social care workers in England.[35]

According to UNISON, there is a likelihood that extending registration to HCAs would cause a shock, but in the long-term it would lead to driving up standards and push the issue to raise pay beyond the current minimum, as well as better workforce planning and a reduction in the risk of longer term harm from widespread staffing shortages. Extending statutory regulation would force the health service to improve standards and reduce both immediate and long-term risks to patients. A key consideration is the cost barrier and the scale of the workforce that would require to be processed; the question of an appropriate fee and who would pay for registration is important as it could be a prohibitive barrier for low paid workers. UNISON notes such problems in the current registration system, with Nursing Associates, who are paid at Band 4 level in the NHS, expected to pay the same annual fees as would a Director of Nursing on a much higher salary. A registration scheme would need to be well designed and accessible as an overly bureaucratic process could hamper recruitment and

33 https://www.nursingtimes.net/news/reviews-and-reports/mandatory-registration-for-healthcare-assistants-07-03-2013/

34 https://www.hcpc-uk.org/about-us/who-we-regulate/regulation-of-further-professions/

35 https://www.change.org/p/department-of-health-and-social-care-make-the-registration-of-care-workers-compulsory-in-england

drive people out of the sector. Measures would also need to be put in place to allow for re-validation and to provide opportunities for continued learning.

## Comparisons to other systems and implications beyond England

The UK lags behind much of Europe in terms of regulation of the health and social care workforce, and as it is no longer in the EU, would not directly be able to contribute to any agreements such as a Common Training Framework. However, it would benefit from lifting standards abroad.

## Poland

The category of HCA ('opiekun medyczny') is a uniform profession that covers workers across all settings including hospitals, community health, residential aged care and homecare. According to the latest data, there were 70,000 HCAs with diplomas, of whom 20,000 work in the health system. There are increasing numbers year to year as more workers are trained. Although HCAs are not registered through a college in the same manner as applies to nurses and doctors, there is regulation of the profession through mandatory qualifications and a state-administered examination process.

## Definition of HCAs and the composition of the workforce

The role was first defined 14 years ago, but recent reforms have facilitated its professionalisation, especially within the public healthcare sector. The key advantage is that only persons who are appropriately qualified are allowed to practice. There are some exemptions in place for older HCAs employed in aged care homes who have worked in the sector long before the introduction of the new regulations.

Significantly, on 26 May 2022, as part of wage increases for all medical personnel, the HCA profession was defined as a medical role (previously it was a general worker).[36] The Polish lower house (Sejm) is currently discussing a bill to define the competencies of the HCA job title, to include aspects such as taking injections, blood samples, and laboratory work. This will further increase the recognition and improve wages and conditions.

There are significant differences in wages and conditions between public hospitals and other settings where HCAs work, including private healthcare and social care. HCAs working in public hospitals can be paid double what HCAs receive employed

36 http://opiekunmedyczny.com.pl/lipcowe-podwyzki-2022/

in other settings. There is consequently an exodus of workers towards the better paid positions, exacerbating the shortages in large parts of the health and social care. Partly this is due to the fragmentation of responsibility for financing – the central government is responsible for public hospitals, but regional governments are responsible for care services. A core priority for FZZPOZIPS and its healthcare union affiliates is to campaign for parity of pay and conditions for all workers.[37]

## Registration and its implications

HCAs are not covered by an equivalent registration process that exists for nurses and doctors, which are administered via Nursing and Medical Colleges ('Izba Lekarska' / 'Izba Pielęgniarska'). Nonetheless, the HCA profession is defined and regulated. As this is deemed to be adequate, there is no active discussion in Poland about introducing additional registration measures for HCAs, and unions are not campaigning in this direction.

HCAs require a diploma qualification to practice and are subject to a state-administered examination; this was a mandatory qualification requirement established in 2011 under the directive of the Ministry of Health. Education of HCAs involves a course of 3-semesters (1.5 years) and is provided by various public and private training institutions. To receive the diploma, students need to pass a final examination, overseen by the Central Exam Commission, a government agency. Students are required to have completed high school education in order to enrol for the diploma course.

## Comparisons to other systems and implications beyond Poland

A common-training framework at the EU level for HCAs is seen as positive from the perspective of trade unions in Poland. It has long been a source country for health and care workers to other EU countries, and in practice, many people completing their qualifications already do so with the intention of working abroad. There is scope to streamline requirements and better align them with skills.

37 http://www.fzzpozips.com.pl/

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