



New skills for new jobs?

Status quo and perspectives for the elderly care sector in Europe

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1. Introduction

The care sector is one of the most dynamic in the EU. Between 1995 and 2001, more than two million jobs were created in the health and social care sector – 18% of total job creation. Employment in these sectors already accounts for almost 10% of total employment in some EU countries (European Commission, 2004; European Foundation 2006: 13-14). In light of the rapid population ageing, this trend is projected to continue, so that the social care sector appears to offer excellent employment growth opportunities for the foreseeable future. The Cedefop report (Cedefop 2008) predicts that by the year 2020 almost three quarters of jobs in the EU-25 will be in services: distribution, transport, hotels and catering are together projected to see employment grow by more than 4.5 million over the next decade, while non-market services (and especially healthcare and social service sector) are expected to increase by slightly more (4.7 million)¹ (tables 1 and 2). The projected increase in the employment rate (for the 15–64 age group), from 65.5 % in 2007 to 69 % in 2020, is, however, mainly due to higher female employment rates (from 58.4 % to almost 63.4 %).

The rapid growth in the demand for care services has met with insufficient supply: a large unsatisfied need for household services is well documented (European Foundation, 2006). Difficulties in expanding care services can be linked to various reasons. On the one hand, financial constraints are leading to reduction in entitlements, greater reliance on home care and cash transfer, and a bias towards informal care. On the other hand, lack of state incentives – such as subsidies and tax breaks - slow down the growth of market demand (as distinct from need) and the creation of a market for care. Finally, the perceived unattractiveness of caring as a career option, the lack of training opportunities and well defined career structures, and low wages all act as obstacles to the creation of an adequate supply of care labour.

Generally speaking, the elderly care sector is a low-pay, low job-quality sector all over Europe. However, the care labour shortage varies widely across countries, reflecting the economic and societal aspects that shape the various care regimes and employment models (Simonazzi 2009). Situated at the point of junction between the paid and unpaid labour divide, care regimes affect the size and dynamics of overall job creation both directly, through the size of the care sector, and indirectly, because of their impact on work-family reconciliation, and eventually on overall female labour supply. Developments in care regimes and in employment models, and the interdependence between supply and demand for care, can thus affect the overall creation of new jobs, the skills that will be needed and the quality of jobs that will be available. It has been argued (Simonazzi 2009) that highly diverse conditions in labour markets and care regimes will result in large cross-country differences in the division between family and market care as well as in the quality and conditions of care jobs. In liberal regimes there seems to be a greater risk of falling into what has been called “a vicious circle of unsatisfactory working conditions, continuing labour shortages and poor service quality” (NESY 2002, p.6). It is an open question, however, whether the only means to achieve good quality employment in the care sector is for government to take a large and direct role as a provider of services, as in the Nordic welfare regimes.

While education requirements are increasing in all occupational categories, thus keeping demand for many highly and medium-skilled workers growing, demand will continue to grow also for many service workers and occupations requiring little or no formal skills, with low pay and poor terms and conditions. This polarisation of jobs raises concerns about social equality and exclusion. Moreover, the expected continued growth in supply of people who have acquired formal qualifications opens the possibility of oversupply in some areas, matched by labour shortages in

¹ Strong positive trends are expected in business services (such as IT, insurance or consultancy), health care and social work, distribution, personal services, hotels and catering, and to a lesser extent education.



some low-qualification services sectors. Placing the prospects for labour supply in the care sector within a wider framework of labour supply and future shortages across Europe as a whole, Coomans (2002) finds that also for the future the care sector cannot take significant supply for granted, since it will be competing with many other sectors in the same predicament. The situation will become even more dramatic since the pool of available informal carer is expected to decrease with the increase in female employment rate.

The long-term sustainability of the care sector thus relies on the development of good quality employment in care. This raises a number of policy questions. Does quality vary between care regimes? And if so, what are the conditions for the creation of good quality employment in care? How do current reforms in the organisation of care affect quality of jobs and care? Finally, if women acquire higher education and better employment opportunities, who will do the (formal and informal) care work in the future in Europe? The following sections will try to provide an answer to these questions. Section 2 provides an overview of the organisation of the eldercare sector in the various care regimes and section 3 suggests the existence of a relation linking the features of the various care regimes and employment models to the quality of care jobs and the size of the care labour shortage. Section 4 then surveys the various policies implemented (or planned) by the various countries with the aim at increasing job quality and labour supply in the eldercare sector. The second part of this section will focus on the effects on job quality that may be expected to derive from the reforms that are taking place in the care sector, in particular the contracting out of public provision to the private (profit and not for profit) sector, the shift in favour of home care, and the increasing role of monetary transfer. Section 5 draws some conclusions.

2. The organisation of the care sector.

Care service provision is strongly influenced by care regimes. An entitlement to care alongside the provision of funding defines different care regimes. Three broad classifications have been devised (European Commission, 1999). In the Beveridge-oriented systems (Nordic countries, UK, Ireland), services are funded out of general taxation and, though universally defined, they are, to a large extent, means-tested or income-related. In the Bismarck-oriented systems (Germany, Austria, France), universal insurance schemes, unrelated to income or means, are intended to prevent deterioration towards a reliance on social assistance, but they do not cover the full costs of long-term-care. In the Mediterranean (Italy, Spain, Greece) and Central-Eastern European countries, families are still the main source of support (Simonazzi 2009). Each grouping allows for a large internal variety of features, hence ability to pay may determine the amount and the quality of care received or the co-payments required. When means are assessed, the reference may be the income and/or the assets of the elderly person, the spouse, or the wider family; and there may be differential rights/charging structures for health care and personal care. On the other hand, as care regimes strive to adapt to demographic and social changes, common trends are emerging that affect the positioning of some of the countries. Thus, as the Mediterranean countries seek to develop more coherent plans for the financing of care they move closer to the two other systems [e.g., see the 'Lei de dependencia' in Spain, the creation of a 'National fund for dependency' in Italy, and the Open care (KAPI) and home care programmes initiated by the Greek government with Community funding]. Conversely, some Nordic countries (such as Finland and Sweden) are promoting a greater role of family care, for instance by introducing cash for care schemes.

The role of the state – in particular as a funder and provider - varies considerably. There is variation in the role of different levels of government: the most market-oriented state, the UK, also has the most controlling national government, while the least market oriented states (Denmark and Sweden) have the highest levels of local control. Broadly speaking, Scandinavian welfare regimes are associated with high levels of services, large workforces and relatively good employment conditions. At the other extreme, the Mediterranean and the newly acceding countries present a



higher reliance on informal/family care. Within the Continental countries, France and Belgium have a fairly developed service for elderly people, while Germany, with its comparatively strong orientation towards informal/ family care, sits closer to the Mediterranean countries. In the acceding countries the process of deinstitutionalisation has resulted in scant provision of services. The care sector has undergone considerable decentralisation, with large regional differences and specific problems in rural areas (Bertolini, Montanari and Peragine 2008). A stronger role of the family meets with a more specific problem, represented by the “care drain” (Bettio et al. 2006) (table 3).

Care regimes may respond to different policy objectives, for example to promote formal services or to encourage informal care by family members (e.g. vouchers versus cash for care schemes to pay family carers), or to support employment creation. This results in a wide variety of specific measures by which these policies are implemented. Therefore caution is needed when making cross-national comparisons of the amount of services provided, since differences in organisation may result in differences in the quantity and the mix of services, as well as in the numbers of people receiving them.

With severe problems of financial sustainability cutting across the various care regimes, solutions have been sought in two directions: reduction of entitlements—targeting services more closely on the population in greatest need—and reduction of care costs. As a consequence of the search for cost effectiveness/reduction we observe a convergence in how the care market is organised: all countries are moving towards home care, private provision and cash transfers (although they still differ greatly in how far they continue to rely or promote informal care or are moving towards professional care).

These trends raise crucial questions for the analysis of care work. In fact, how costs are shared, funding is ensured, and services are provided are of consequence for the quality of employment of workers and on the development of the care sector on the whole (with regard to professionalisation, training, career options). Generally speaking, a high level of public funding makes it more likely that workers will be well trained and paid, and have high quality of employment, although training and pay need not be necessarily associated, as the German case shows: elderly care workers and nurses are generally very well trained (three-year courses) and yet pay and working conditions are relatively poor. Other issues are equally less clear cut. For instance, what are the employment consequences of the shift to home care, supported by monetary subsidies, such as ‘cash for care’? (These aspects will be dealt with in section 4 below.)

The European countries are implementing these major reforms in their various ways, through a variety of “internal” reforms that take place in the field of elderly care. These strategies of rationalisation represent the national responses to the growing demands for quality assurance and professionalisation of social carers and nurses on the one hand and the limited budgets on the other (Zimmermann, 2008). However, as care services are moving ever closer to other areas - education, housing, and especially health - the attainment of high quality employment, including a high level education, may require to develop care occupations that span a wider spectrum of competencies (Care work in Europe, 2002 wp.6: 4-5).

3. The care labour market²

3.1 Job quality and skills. Generally speaking, elderly care is characterised as a low-pay, low-status sector. Long-term care workers share many of the same features across countries. The overwhelming majority of care workers are female and many are aged 45 and above, which is somewhat older than the total workforce average. They face problems concerning pay, hours, training and status. Coverage by collective agreements varies across countries and between public

² This section draws on Simonazzi (2009).



and private providers, but fragmentation of unions among skills and tasks, and the decentralisation and fragmentation of bargaining - encouraged by the fragmentation of employers (public, private subcontractor, for-profit, non-profit) - are features common to all countries³.

The way work is organised and jobs are performed within a sector have significant implications for occupational skills and job quality. We observe huge cross country differences in care job quality and the degree of wage compression. In the Netherlands, for instance, care work is paid better than other low paid sectors, while the opposite is true for the UK, where the minimum wage sets the level for care work pay. In Sweden the cross-sector wage differential is much narrower than in the Mediterranean countries.⁴ Institutional and cultural factors and policy choices can explain these differences. Those countries aiming at narrower wage dispersion have resorted to two main policies: technology and training, and public provision.

Moreover, there is a wide disparity in working conditions across employers and types of care, and earnings vary between different groups of care workers. Full-time workers in the largest group in the ELFS ('personal care workers') earn less than the average for all full-time employees, while part-timers earn around the average (except in the UK). Pay and conditions are usually worse for staff employed by private contractors in comparison with in-house staff directly employed by public institutions, and for workers in home care compared with those in residential care. Indeed, better public sector working conditions, which translate into higher labour costs, have encouraged the contracting-out of services to private providers. Low wages (generally lower than the national average) and poor employment conditions result in very high turnover rates and recruitment problems, in large part because of competition from equally low-paid, but less stressful sectors. Unskilled workers often move to and from jobs in a variety of service industries as opportunities arise. In the UK, for instance, minimum wage legislation has been important in setting a standard wage for low-pay sectors, with the result that it may have increased employee departures from care in favour of other minimum wage paying sectors offering less demanding working conditions (such as supermarkets). In Italy, regularisations have produced similar effects: after regularisation, immigrant workers seek to move into non-profit service providers, or out of care into other sectors (such as hotels). Atypical contracts are common, but high turnover and vacancies are due more to poor job quality than to job precariousness, given the existence of excess demand for care labour in most countries. Turnover rates are higher in private than in public services, so that they are higher in those countries in which commercial services dominate the market (Christopherson, 1997).

Levels of trade union membership vary greatly across countries – from over 80 percent in Denmark and Sweden to less than 20 percent in Spain. The role of trade unions also varies. They are active participants in collective bargaining for the pay and conditions of care workers in Scandinavia, Hungary and the Netherlands, but play little part in the private care sector in the UK where most care workers are located. The research mentioned above (Care for work in Europe 2002) suggests that trade unions and collective bargaining are important structural factors when considering employment conditions - though there is no simple causal relationship. Strong unions may also play an active training, professional and political role (with sometimes unexpected results, as pointed out by the case of the latest national contract of domestic workers in Italy, in Box 2 below).

There are wide cross-countries differences in the levels of education, training and credentialing for formal care workers, that closely reflect the country's national employment model. Generally

³ Allowing for certain differences within the sector and between countries, the Report of the European Foundation for the Improvement of Living and Working Conditions has found a broad consensus concerning the following – largely negative – aspects of social care employment: relatively high rates of turnover of staff, especially in basic care work; lack of younger entrants into social care; high reported levels of stress and 'burn out'; high proportion of older workers; relatively low pay and prestige; frequently non-standard working hours; under-developed career structures and prospects (European Foundation 2006).

⁴ In Italy, for instance, using data from the 2002 Survey on Household Income and Wealth (SHIW), Addis (2008) estimates a 17% wage penalty of the domestic sector relative to industry.



speaking, such levels are mostly low for care workers in the Mediterranean countries, France and the UK: employers offer induction programmes that may last for anything between two days and two weeks. They are reasonably high for skilled and semi-skilled workers in the vocational systems of Austria and Germany, and they are the highest in Scandinavian countries. Working conditions in the care sector in the newly accessing countries are generally worse than in the EU15 (Care work in Europe 2002; European Foundation 2006). Most research has argued in favour of a clear relation between levels of training and levels of pay: Denmark is high on both, the UK low. But the exception of Germany stands out. It seems therefore that these features and their correlation seem to be related to the interaction between different care and employment models.

As noted, Scandinavian welfare regimes are associated with high levels of services, large workforces and relatively good employment conditions. Compared with other countries, the Nordic care regime requires one of the highest levels of education among caregivers and pays the highest wages. Sweden's system of long-term care services, for instance, is designed to support women in the workplace and to professionalise care-giving to older people needing help (Anxo and Fagan 2005). According to some estimates (Alaby 2005), 10% of long-term care workers have university degrees in health and social work, and the other 90% are nurse assistants and home helpers; approximately 60% of these paraprofessional workers have completed vocational training. Sweden is thus in relatively good shape regarding its supply of nurses, physicians and health care professionals. In the UK, social workers are expected to be qualified and registered with the relevant authority. However, care service jobs have been traditionally classed as manual work requiring no formal qualifications for entry (in line with many manual jobs in the UK labour markets). With the increasing marketisation of services, cost pressures have reinforced the development of a low-paid and casualised workforce (Escobedo et al., 2002; Urwin and Rubery, 2006).

In France, the development of long-term care services has reflected an employment policy intended to increase labour force participation among low-skilled people (Korzcyk, 2004). The *chèque emploi* service is the instrument devised to favour regularisation and to prevent the creation of an informal market. It proves the existence of a regular contract, and is required when application is made for rebates on taxes and social contributions. This policy has encouraged private contracts, with negative effects on pay and work and care quality. Private contracts, in fact, tend to pay less than formal jobs with private or government agencies, and they do not offer any career progression. Lower wages provide limited incentives for employees to seek training that might improve their earnings, their career mobility or the quality of care that they provide. Consequently, while both the allowance and the availability of family employment may have increased the number of formal care jobs, they may also have increased the proportion of care jobs governed by inherently precarious personal services contracts, rather than more stable employer–employee relationships (Christopherson, 1997; Korzcyk, 2004). By making the direct employment of home carers more financially advantageous (because of fiscal benefits), this policy has favoured the transformation of non-profit organisations from direct providers into labour agencies (intermediating between demand and supply) (Lima, 2006). In consequence, the care workforce in France has been split into two broad groups: one group of workers with the formal training necessary to pursue a career, the other essentially unskilled labour, with few prospects of upward mobility (Christopherson, 1997). The evolution of training in the French home help sector has reflected the tension between, on the one hand, the development of home help as a service with increasingly complex professional demands and, on the other, as essentially an employment programme. Some observers believe that France has made a trade-off between increasing access to employment for untrained workers and increasing employee qualifications to improve service quality, and they conclude that the system has privileged employment generation over the quality of care and jobs (Korzcyk, 2004). It should be noted, however, that the Scandinavian countries show that treating care work as a source of jobs, and also using it to provide needed services, are goals that do not necessarily conflict with quality.



In Austria and Germany, the professional system is finely divided, and a complex array of credentials is required from workers in order to practice their professions. Different levels of skills, sanctioned by various levels of licenses and credentials, determine a complex segmentation of the care market. In Austria, there are two different levels of qualifications: one for skilled staff, such as graduate nurses, and the other for semi-skilled staff, which includes assistant nurses and home helps. Graduate nurses must complete a three-year course, but their diploma does not count as a higher-education entrance qualification. Assistant nurses must complete a one-year course (the one for home assistants is much shorter). Courses are offered by a multiplicity of institutions and retraining courses have been organised for unemployed or existing care workers. The lack of country-wide training standards means that assistant nurses must obtain formal approval of their training certificates when they move to another province. Although the proportion of skilled staff has increased over time, it is increasingly difficult to find skilled personnel, in particular for home care services (Hermann, 2006). In Germany, elderly care work has been an autonomous profession with standardised vocational training at the federal level since 2003. The contents of the training are regulated by the federal law on care for elderly people, although the training itself is the responsibility of the Regions. Trainees are required to have a leaving certificate from secondary school (Realschueler or equivalent) and the duration of the training is three years (full time), followed by a six-month probationary period. In Germany, employees with professional training in elderly care are mainly qualified as nurses or as elderly care workers. Home care is provided by professional staff, with whom the LTC insurance funds stipulate supply contracts.

Currently, Germany does not have a shortage of adequately trained nurses or elderly care workers, but there is already evidence that personnel with additional advanced education that is necessary for certain tasks within elderly care is starting to become scarce (Hieming et al. 2005). The recent (and still ongoing) structural changes in the hospital sector have led to severe cutbacks in jobs (a minimum reduction of beds by 30% is expected). Hence, there is currently enough staff available for recruitment by nursing homes and/or home care services (in competition with elderly care workers). Moreover, the current and future demand for elderly care workers could easily be satisfied by so-called retrainees (Umschueler) who have attended training courses partly supported by the Agency for Labour. Due to policy changes, however, this pool of supply is likely to drain out in the near future. In their endeavour to reduce costs, private providers are employing under-qualified or untrained staff to an extent largely in excess of the 50% rate of fully trained personnel (Fachkraftquote) per establishment fixed by law. As a consequence, the share of unskilled workers and people under-qualified for their jobs has been rapidly increasing since the introduction of the long-term care insurance in 1995 and 1999, and it is still comparatively high. Recently, however, there has been an inversion in the trend, with the share of qualified personnel increasing again, and the proportion of employees without any health care training and of unskilled personnel diminishing in both home care services and nursing homes (table 4). This phenomenon is somewhat surprising, given the high pressure on costs that the eldercare sector tries to meet by reducing labour costs. At the same time, we observe the emergence of a parallel market for (often illegal and mainly East European female) health-care workers. This combination of qualified and less qualified workers, and irregular workers, points towards a high degree of labour segmentation.

In the Mediterranean countries, the labour market for elderly care largely consists of informal carers. These workers, as well as many of those in the formal market, have low levels of education and skills. In the case of immigrant carers, the level of education may be fairly high but not focused on care, so that there may be a mismatch of qualifications—as in the case of immigrants to Italy from Eastern Europe.

Public action aimed at encouraging worker upskilling and professionalisation of the sector is on the rise everywhere, both through training courses and certifications, and through more stringent regulations and credentialing. Training is indeed necessary to ensure good-quality care, and to provide the horizontal and vertical career mobility required to keep workers in the profession.



Moreover, the training of care workers, particularly those who provide home care, grows increasingly important as medical advances and the shift to home care permit more people with complex needs to live in the community rather than in specialised institutions. Training policies are not without problems, however. Firstly, training often does not pay in terms of wages or career. In many countries, there is easy access to lower-skilled occupations in elder care, but little vertical or horizontal mobility once workers are in the profession. This lack of career mobility may turn care work into a dead-end occupation, both in the perception of potential employees and in fact (Korczyk, 2004, p. 6). Access to more professionalized occupations, such as nursing, requires advanced formal training and often totally separate curricula. The segmentation of the market is highest where the professional system is most finely defined (as in Germany and Austria), or where there is a large presence of illegal/irregular carers: attempts to increase the qualification level of lower skilled workers (e.g. immigrant care workers in Italy) may be opposed by other, less professionalized (national) care workers, or by health professionals (as in France and Germany). Since most training and credentialing is done at the local level, there is the risk that it may lack recognition at the regional or national level, while the fragmentation of training courses may create a barrier to upward mobility. Making regulations and credentialing more stringent may also conflict with the characteristics of the supply of carers: in Spain—where educational requirements in the public sector are both rigorous and formalised and local governments stipulate that companies offering home care services must hire workers with at least 750 hours of family work training—there is concern that regulation of training requirements and qualifications may force out women with lower educations (Miguélez, Lope, and Olivares 2006). Conversely, many workers are over-qualified for the positions they occupy, as in the case of foreign nurses and other professional care workers in the UK (Experian, 2007).

3.2 The size of the care labour market.

Inadequate data at national level and problems with the harmonisation of international statistics make estimates of total employment very problematic. At the national level, two characteristics of the care market – its integration within the broader social sector and the high share of the informal market – make it difficult to obtain reliable data relating to elderly care. The contiguity of long-term care with health and social services means that flows between these sectors are quite common, so that the boundaries among different occupations tend to be blurred. Because the markets, the credentialing, and the data gathering are not distinct, data usually relate to broad categories of workers. This means that the specific occupations in elderly care do not fall neatly in the ISCO (International Standard Classification of Occupations) occupational groupings which are provided on an annual basis by the European Labour Force Statistics (ELFS) for all member states. Moreover, since the structure of the care workforce may vary in the different countries, and it may change in response of socio-economic and policy changes, the allocation of occupations across different ISCO categories may vary between countries. Thus, although ISCO provides a harmonised classification system of occupations, the process by which the system is applied to national data by member states is not harmonised⁵. Data provided by national country reports show that estimates of care work can vary substantially in quantity and detail between countries and occupations, even when they are limited to the formal segment of the care labour market (see table 6, for national estimates and table 7 on German national data). For these reasons, comparative data of the ELFS should be treated with caution.

Table 5 provides an estimate of the total number of care workers in the 25 EU countries, computed from the ISCO 1988 database relative to the year 2000. The data refers to ‘front-line workers’: this excludes a wide range of workers who are involved with care services, often providing specialist

⁵ One solution, already used by a number of member states, would be for all member states either to code occupations directly into the ISCO system, or to apply both national classification systems and ISCO to their national data (Care work in Europe, 2002).



knowledge and skills⁶, but includes a much wider range of social workers, not involved in elderly care (see Box 1). The new ISCO Classification (2008) provides a more detailed classification which fits closer to eldercare occupations⁷, but we were unable to obtain the data according to this classification. The second part of the table (table 5b) gives the share of care work in total employment, distinct by care sub-groupings. It should be noted that a substantial proportion of care workers (who are mostly women) are employed part time (see table 7 referring to the case of Germany). Since the share of part time workers in care is higher than in total employment, the amount of care paid work as a proportion of the total volume of employment in full-time equivalents will be lower. Finally, we should remember that these estimates do not consider informal/irregular carers (see table 6 for estimates of the irregular migrant care workers in some EU countries). For all these reasons, both estimates of total employment (table 5) and cross-country comparisons should be treated with caution.

Box 1: ISCO occupational groups

We include the following categories of the ISCO Classification (1998):

223 nursing and midwife professionals

Nursing and midwifery professionals apply medical concepts and principles relating to the delivery of babies and to nursing of the ill, injured or disabled, and of mothers and their newborn babies. Tasks performed usually include: helping medical doctors in the practical application of preventive and curative measures and dealing with emergencies in their absence; providing professional nursing services, care and advice for the sick, injured, physically and mentally disabled and others in need of such care, and directing auxiliary nursing staff; delivering or assisting in the delivery of babies, and instructing mothers in baby care. Supervision of other workers may be included. It should be noted that, depending on the specific tasks and degree of responsibility in executing them, as well as on the national educational and training requirements, it may be appropriate to classify some or all of the occupations that are identified here into Minor group 323, Nursing and midwifery associate professionals.

323 nursing and midwife associate professionals

Nursing and midwifery associate professionals apply medical concepts and principles relating to the delivery of babies and to nursing of the ill, injured or disabled, and of mothers and their newborn babies. Tasks performed usually include: helping medical doctors, or nursing and midwifery professionals, in the practical application of preventive and curative measures, and dealing with emergencies in their absence; providing nursing services, care and advice for the sick, injured, physically and mentally disabled and others in need of such care; delivering or assisting in the delivery of babies, and instructing mothers in baby care. Supervision of other workers may be included. It should be noted that depending on the specific tasks and degree of responsibility in executing them, as well as on the national educational and training requirements, it may be appropriate to classify some or all of the occupations that are identified here into Minor group 223, Nursing and midwifery professionals.

⁶ It excludes, for example, psychologists and various types of therapists, but also managers. In some cases, the latter are, in fact, ‘front-line workers’: for example, the Swedish national report, conducted within the project “Care Work in Europe”, argues for including middle managers in services for elderly people because, “due to the low educational level in elder care, [this manager] has an important role as a supervisor and organiser of care work... (and) has an education at university level” (reported in Care work in Europe, 2002: 37).

⁷ For instance the item 223 of the ISCO88 is now broken down into 6 subcategories, of which item 1343 refers to ‘Aged care services managers’ (see the correspondence table in: <http://www.ilo.org/public/english/bureau/stat/isco/docs/corrtab88-08.xls>).

346 Social workers associate professionals

Social work associate professionals provide guidance to clients in social and related matters to enable them to find and use resources to overcome difficulties and achieve particular goals. Tasks performed usually include: helping individuals and families with personal and social problems; working to prevent development of delinquency or to achieve rehabilitation by organising and supervising social activities of individuals and groups; helping physically or mentally handicapped persons to obtain adequate treatment and improve their ability to function in society. It should be noted that, depending on the specific tasks and degree of responsibility in executing them, as well as on the national educational and training requirements, it may be appropriate to classify some of the occupations that are identified here into Unit Group 2446 Social work professionals.

513 Personal care and related workers

Personal care and related workers provide child care and help in looking after schoolchildren, perform various tasks in order to assist medical and nursing professionals and associate professionals in their duties at hospitals and other institutions, provide home-based personal care, or help veterinary, pharmaceutical or other professionals in their tasks.

Tasks performed usually include: taking care of employers' children and helping teachers by taking care of children at lunch or other school breaks or outings; providing rudimentary nursing and related care in hospitals and similar institutions, or to patients at home; helping veterinary and pharmaceutical professionals in their duties. Supervision of other workers may be included. Occupations in this minor group are classified into the following unit groups:

5131 Child-care workers; 5132 Institutions-based personal workers; 5133 Home-based personal care workers; 5139 Personal care and related workers not elsewhere classified.

913 Domestic and related helpers, cleaners and launderers

Domestic and related helpers, cleaners and launderers perform various tasks in private households, hotels, offices, hospitals and other establishments, as well as in aircraft, trains, coaches, trams, and similar vehicles, in order to keep the interiors and fixtures clean, or they do hand-laundering and pressing. Tasks performed usually include sweeping or vacuum-cleaning, taking care of linen, washing and polishing floors, furniture and other objects, or bed-making helping with various kitchen work or, in private households, cooking and serving meals; performing the tasks of hand-launderers and pressers. Supervision of other workers may be included.

Occupations in this minor group are classified into the following unit groups: 9131 Domestic helpers and cleaners; 9132 Helpers and cleaners in offices, hotels and other establishments; 9133 Hand-launderers and pressers.

Source: ISCO 88: <http://www.ilo.org/public/english/bureau/stat/isco/isco88/major.htm>

The data of table 5b are plotted in figure 1. Although the proportion of the 'care' workforce in total employment varies across countries (only three countries – Sweden, Denmark, and France - have a share of care workers in total employment above 10%), it is at a more disaggregated level that the differences are more distinct. The Nordic countries tend to perform better in the occupational groups of social workers professionals and personal care, while they fall behind the Mediterranean countries in 'domestic and related helpers'. France is performing relatively well in all sub-groupings, and its overall performance may be the outcome of its employment creation policy. Austria and Germany perform better in certified professions (nurse and midwives and social workers professionals), while the data for Central and Eastern countries confirms their lack of social care professionals⁸. In general, Figure 1 illustrates the large difference in care work employment (both amount and structure) in countries with care services at very different stages of development.

In the remaining part of this section we provide, by way of comparison with the ISCO estimates, various estimates drawing on national sources (table 6) and the latest estimates of care workers in Germany. National sources estimates vary significantly across countries, with the best information coming from countries with the highest levels of services and public funding.

⁸ Data for Bulgaria, Romania and Malta is missing.



In Germany, the number of care workers in home care and nursing homes has been increasing dramatically since the last decade: 30% between 1999 and 2007, with a higher increase for the nursing home sector relative to the home care sector. However, as indicated in table 7, the bulk of the gain has been in the part-time and marginal employment⁹ segments, whereas the share of full-time workers has been constantly decreasing. The proportion of part-timers has been traditionally high within elderly care work, and especially so within home care. Conversely, the recent trend away from full-time positions is much higher in nursing homes.

In Germany, a high share of part-time and marginal employment is typical of female-dominated occupations. This pattern can be due, directly or indirectly, to the German welfare state (Esping-Andersen 1999, Voss-Dahm 2009): one out of five women working part-time do so because of care and families obligations (Mikrozensus 2006, authors' calculations). It may also be a result of the German long-term-care insurance (Kuemmerling 2009). The care market in Germany is highly regulated – the way care suppliers are to offer their services and the way care is paid for is regulated by law (Hieming et al. 2005). As a consequence, providers do not have many options open in order to save costs, the main leverage being represented by personnel costs. Normally, staff costs in the elderly care sector amount to roughly 70% of total costs, but some private providers already managed to lower them to 50%, by:

a) Employing a disproportional amount of under-qualified or untrained staff (this applies in particular to private providers); b) ignoring the 50% rate of fully trained personnel per establishment (Fachkraftquote) that is fixed by law; c) exerting time pressure (this applies to all provider groups); d) paying wages below the agreed upon tariff wage floor and d) contracting out many services (such as laundry, cleaning, kitchen) (this applies in particular to nursing homes in all provider groups). In this regard, it is profitable to employ part-timers, in particular marginal employees, since for this group the net pay equals the gross labour cost and lower hourly wages can be enforced. Moreover, part-timers are often more flexible when it comes to overtime hours (Kuemmerling 2009).

3.3 The care labour shortage.

Demand for care labour is increasing rapidly, and all countries are experiencing problems in recruiting enough workers to meet demand. Various approaches have been implemented or suggested to tackle shortages. These include: improving the level of training, education and professionalisation; improving employment conditions; extending recruitment sources, in particular to under-represented groups; and resorting to migrant carers.

In some countries, the shortage of care workers has been met by a large inflow of immigrant, mostly female, workers. The magnitude of the labour shortage in the LTC sector, in total and across the skill spectrum, the extent of recourse to migration to fill the gap, and the modes of migrant involvement in the labour market differ widely across countries and across the various segments of the care labour market. The UK is one of the largest importers of professional health care workers, a large percentage of whom work in the long-term care system, but it has not relied on immigrants for unskilled, personal care. Germany by contrast, has not experienced a lack of professional workers, while a parallel market for (often illegal and mainly East European female) health care workers seems to have emerged in recent years. Estimates of the numbers of live-in migrant carers are by nature problematic, but it can be reasonably assumed that around 100,000 illegal carers are working in Germany (Lutz 2007). These workers co-reside with the elderly person round-the-clock, and stay for a three-month period on a rotating basis. Illegal carers are incomparably cheap and raise serious competition against home service providers (the latter have reported an up to 30% loss of turnover,

⁹ Marginal employed (Minijob-holder) means that the employee is not allowed to earn more than 400 Euro per month on average. Since marginal employment is excluded from paying social security contributions and income taxes, it provides incentives to labour supply and demand.



Frischhut 2006). Substantial cash benefits, little regulatory oversight, and a tradition of home care have encouraged extensive use of foreign care workers in Austria. Many of them are illegal but are openly recruited by agencies for short-term, rotating care work. Legal immigrant carers are more numerous in residential care (where they account for two-thirds of staff), than in home care, mostly because of language problems (while language does not seem to be a problem for the employment of undeclared workers in households) (Hermann 2006). Mediterranean countries, too, have relied on immigrant workers to supplement family carers; unlike in the UK, many of these workers are undocumented immigrants, hired informally by families through informal networks or through the church. In the three Mediterranean countries, foreign (mostly female) workers furnish an increasing share of home care: the underground economy covers one-third of the market in Spain, where language is less of a problem, since workers migrate from Latin American countries. More or less legal flows from bordering Eastern countries are supplying the market for informal carers in Greece and Italy. Conversely, France and the Nordic countries seem to rely least on immigrant carers. Denmark has tackled an earlier shortage among its most highly trained care work group (pedagogues), but it is experiencing shortages in social and health assistants, an occupational group with lower levels of training. With a general increase in the levels of qualification, it is in fact increasingly difficult to recruit students for this lower qualified work. In Sweden too, substantial public spending has resulted in a largely native workforce, which is well paid and highly trained. There is a small but growing number of foreign-born workers mostly employed by public agencies. In spite of a very different employment policy, native care workers are still predominant in France.

When irregular carers are included (when estimates are available) one observes a convergence across countries in the ratios of ‘carers’ to the population aged over 65 (see table 6 and table 5c for comparison with ISCO data).



Box 2. The role of migrant carers: the case of Italy

On July 3rd, 2009, on the wave of a largely publicised campaign, the parliament passed a security decree which defines illegal immigration a crime¹. Barely two days later, representatives of the party in power hurried to reassure the electorate that the law would not apply to the “badanti”, as the migrant female carers employed mostly illegally in the care of elderly people are called. One week later, an amnesty was announced to regularise the 500.000 foreign illegal minders estimated to be employed in the elderly care sector.

What this episode conveys is the desperate need of Italian families for help in providing LTC for the elderly and the crucial role that migration is playing since more than two decade in responding to this need. A need which has grown so strong as to force the government to partly retract its just approved law and to pass yet another regularization operation. Just like in 2002, and in the many times before, a new law will be enacted primarily in order to give Italian families the opportunity to legalize the status of their foreign ‘helpers’ or ‘minders’.

In fact, in spite of rapidly increasing permits issued for immigrants to work in the household services sector, demands from families kept exceeding the permits issued by an order of four (table A). The immigration policy pursued by the Italian government, based on *ex-post* calls to regularize rather than a clear *ex-ante* plan, helped perpetuate this state of affairs by periodically replenishing the pool of irregular labour.

Table A – Quota permits for non-EU workers: decree on flows 2005 - 2008

	Total permits	Of which: Non-seasonal workers	Number of nominal requests received by the Ministry of the Interior	Quota set aside for household services and personal care	Number of requests received by the Ministry of the Interior for personal care
2005	79.500	30.000	250.880	15.000	56.000
2006	170.000	120.000	540.000	45.000	200.000
2007	170.000	170.000	720.000	65.000	391.864
2008	150.000	150.000	*	105.400	*

Source: Piperno 2009.

* In 2008 the practices for the presentation of the requests have not been activated.

In the Mediterranean countries, female migrants have met unsatisfied needs for care while ensuring the continuity of a family-based long-term care model. They provide long-term care at prices which middle-income families can afford. They fill a widening gap between family care and professional (public) care, so that the main tasks of families are organizing and monitoring the minders’ work. This eases reconciliation between otherwise conflicting concerns: on the one hand, widespread aversion to institutionalization coupled with a traditional, family-centred care model where children/daughters are responsible for their parents’ care; on the other hand, a dwindling supply of daughters living sufficiently close and willing to sacrifice employment. Unconditional monetary transfers, like the



attendance allowance and the care allowance, have helped spread the foreign minder solution down to low-income families (Bettio et al 2006).

A complex division of labour developed whereby family carers (mainly women) provide the coordination, while the task of minding is entrusted to the female immigrant, and more skilled as well as prevalently native workers – private or public – take on paramedical tasks where and when needed. A complex segmentation of the market along gender and ethnic lines has thus arisen from an abundant supply of cheap labour combined with a limited supply of specialized public services.

The “Mediterranean model” of care raises issues of social equity and long-term viability. Since the availability of a cheap alternative inhibits demand for, and crowds out, the supply of specialized care, any policy by local authorities to favour the ‘emersion’ of informal contractual arrangements and the regularization of foreign workers in order to reduce discrimination, or to upgrade the skills of foreign carers and reduce segmentation, is likely to meet with scant interest from families (and outright hostility from social workers faced with increasing competition). Until very recently, families have had no incentive to regularize the workers in their employment, since sums paid by the family for care work were not tax deductible. In 2000, deduction was finally introduced, but only for payment of social contributions. Families are more concerned that local authorities should help ensure that their demand is matched by quality supply, for example, by screening immigrants to ensure their trustworthiness (a role traditionally performed by the Church) and helping them to learn the language.

Other factors challenge the long-term viability of this care regime. As more people with a career of precarious jobs will reach retirement, their pensions, if not complemented by other sources of income or by monetary subsidies, may be insufficient to buy the care services in the market, even at the lower cost of an illegal live-in minder. This implies that any attempt to raise the pay and working conditions of regular carers might price them out of the market, making their services unaffordable to lower income families.

The capacity of the Mediterranean care regime to move towards a more regulated, higher quality care market will depend on the coordination of the different policies that will guarantee both families’ capacity to pay and better conditions in the care labour market. The case of the new national contract for domestic workers (in March 2007) provides a good example of a possible trade-off. The new contract raised the cost to a family of a live-in elderly minder on a regular contract to a level roughly comparable to the average female net earnings in industry and services (1000 - 1300 euros per month for the live-in carer, in addition to board and lodging costs, versus 950 – 1250 euros for the industry wage). With these new wages, even if social contributions can be deducted from tax, the regular minder solution is no longer sustainable for lower-middle income families, which used to rely on the extremely cheap supply of informal carers, and it is no longer competitive with residential care, especially if the latter receives a state subsidy. The risk is therefore that this form of work will be pushed back into the black market. If this is to be prevented, both the level and the conditions regulating the provision of monetary transfers need to be monitored: the level should be in line with what is considered a fair wage in the care market, and the transfer should be earmarked in order to guarantee that conditions are met (Simonazzi 2009a).

¹ The law provides that an undocumented immigrant could be fined an amount from 5 to 10,000 euro, and then arrested and condemned up to five years of prison if he does not obey an expulsion order. The family, in turn, could risk up to two years of prison for hosting an illegal immigrant.



4. Policies for better care jobs

What conditions are necessary for the development of employment that is both of good quality and sufficient to meet growing demand? The European Commission (2001) has suggested 10 broad domains related to quality of employment, including: intrinsic job quality, skills, life-long learning and career development, gender equality, health and safety, work organisation and work-life balance, and diversity and non-discrimination. Related dimensions, which might also need to be considered, include pay and employment conditions. Escobedo et al (2002) suggest that the most important aspects of working conditions for carers are working hours, employment status and pay. As the previous analysis has shown, these features of care labour cannot be tackled simply by measures within the care labour market, for instance by increasing education and training, but depend on the functioning of the labour market on the whole, that is, from the various employment models. Where job quality is generally good, care work quality will also be relatively good. Moreover, the poor standing from which care work suffers in all EU countries seems to be connected, first and foremost, with the fact that paid care work is equated with unpaid care work, thus suffering from the same devaluation that unpaid activities endure. In this section we shall review the most common measures advocated and/or implemented within the care sector in order to improve workers' competencies and job quality. In the second part, we shall briefly analyse which effects can be expected from the current reforms in the various care regimes, focusing on their consequences on the division between formal and informal markets and on care work in general.

4.1 Policy measures for job quality

Training. Public action aimed at encouraging worker upskilling and professionalisation of the sector is on the rise everywhere, both through training courses and certifications, and through more stringent regulations and credentialing. Training is indeed necessary to ensure good-quality care, and to provide the horizontal and vertical career mobility required to keep workers in the profession. Moreover, the training of care workers, particularly those who provide home care, becomes increasingly important as medical advances and the shift to home care permit more persons with complex needs to live in the community rather than in specialized institutions. Training policies are not without problems, however. Firstly, training often does not pay in terms of wages or career. In many countries, there is easy access to lower-skilled occupations in elder care, but little vertical or horizontal mobility once workers are in the profession. This lack of career mobility may turn care work into a dead-end occupation, both in the perception of potential employees and in fact. Establishing a set of basic rights for workers in the care services (paid holidays, sick leave, right to training etc.) is also important. Training and accreditation programmes should be sufficiently vocational in nature to ensure that workers develop relevant practical skills as well as academic recognition. However, this may lead to a greater segmentation of the market. The segmentation of the market is highest where the professional system is most finely defined (as in Germany and Austria), or where there is a large presence of illegal/irregular carers: attempts to increase the qualification level of lower-skilled workers (e.g. immigrant care workers in Italy) may be opposed by other, less-professionalized (national) care workers, or by health professionals (as in France and Germany). Moreover, making regulations and credentialing more stringent may also conflict with the characteristics of the supply of carers, raising concern that regulation of training requirements and qualifications may expel women with lower educations (such as in Spain).

Accreditation: national or EU standards. Since most training and credentialing is done at the local level, there is the risk that it may lack recognition at the regional or national level, while the fragmentation of training courses may create a barrier to upward mobility. Recognition of qualifications at an EU level can enhance the employability and professional mobility of employees, both sectorally and geographically, while giving care workers a more structured and 'professionalised' career path. Moves towards standardisation, however, may run counter potential problems concerning restricted access to better posts, leading to less qualified workers continuing to



work in the ‘undeclared sector’, as well as higher labour costs which could affect demand (Cancedda 2001; Simonazzi 2009; Miguélez, Lope and Olivares 2006).

An important question relating to training, education and professionalisation relates not only to the levels of training, as to how the competencies should be structured: should we move towards generic or specialised qualifications, ‘care workers’ or a type of worker with levels of competencies beyond the care for elderly people. The ongoing reform of the elderly care sector will entail changes in the organisation of the entire care chain calling for new occupational positions and new competencies for the coordination of the various stages in the care cycle and among the various authorities in charge of funding, providing or supervising care services.

Formalising informal/undeclared care work. The rise in undeclared work poses a major threat to achieving higher standards of care provision within the formal sector and to securing improvements in job quality. Undeclared care workers are denied even the more basic rights that are enjoyed by formal paid workers, such as access to appropriate employee rights and protection, as well as job-related training and career progression opportunities. Various policies have been implemented to encourage the regularisation of undeclared work in the sector: on the supply side, measures such as amnesties, incentives to regularisation, training courses for migrant carers, on the demand side measures aimed at strengthening families’ purchasing power through “tied” cash subsidies, tax credits or tax exemptions for households employing a care worker on a formal basis. A significant proportion of the resultant ‘new’ jobs correspond to the formalisation of the previously undeclared labour (European Foundation, 2006: 65).

Information technology (IT). Various forms of IT in social care can partly substitute for human resources and so make social care less labour intensive and up-grade the competencies of the work force. Investment in new forms of residential care and adoption of new technology and innovation can also postpone institutionalisation. There is, by now, a long list of good practices documenting the adoption of IT devices in support of home care and cost reduction (Bertoni and Solinas 2008)¹⁰. For example, home based mechanisms for voice communication and emergency calling can reduce monitoring visits by care staff and delay or avoid admission to residential care. On-line self-assessment packages are being tested as an alternative to time consuming face-to-face interviews with staff (Care work in Europe, 2002). While the introduction of new technologies can leave room for different, more professionalised profiles of care workers, there is concern over the consequent reduction in human contact for often lonely and isolated elderly people (Bettio et al 2006). If the use of IT becomes more widespread then the loss of human contact should be addressed in other ways, e.g. through volunteer visiting and befriending schemes.

4.2 Reforms of care regimes: implications for job quality.

As a consequence of the search for cost effectiveness/ reduction we observe a convergence in how the care market is organised: all countries are moving towards home care, private provision and cash transfers. It has been argued elsewhere (Simonazzi 2009) that these trends can affect deeply the organisation of the care sector as well as the quantity and quality of the care workers. Downscaling of institutionalised care (contracting out) may result in worsening labour conditions if, as is normally the case (UK, Italy) private contractors must work with tighter budget constraints. Competition in the “social market” for care needs thus to be regulated and supervised, in order to avoid that it turns out in worsening job and care quality. The same caveat applies if unconditional,

¹⁰ The EU project Wel_hops (Welfare housing policies for senior citizens) has investigated the possibilities opened up by smart houses to allow weak, elderly people to stay in their own homes longer, thus postponing insitutionalisation. <http://www.welhops.net/ita/index.asp>

See also the research project ‘Independent living for elderly’, <http://www.ict-ile.eu/> ; Nordic Cooperation on Disability (2004), and *Provision of assistive technology in the Nordic Countries*, Stockholm, 2004, http://www.nsh.se/publikationer/provision_assistive_technology.htm



cash for care schemes may turn out in encouraging the undeclared/irregular market for care (Simonazzi 2009a).

We argue that the process of job creation in the social market for care - which derives from the contracting out of previously publicly provided services and from the ‘externalisation’ of caring activities traditionally provided for by the family, which is promoted through the provision of monetary subsidies – needs the firm governance of the public authority, if undesired consequences on the care labour market are to be avoided.

4.2.1 Public-private provision

Denmark seems nearest to achieving employment of good quality in care and does not seem to exhibit (current and prospective) shortages in care labour supply. The UK, conversely, has one of the lowest quality of care jobs and huge shortages in care labour supply. Indeed Denmark illustrates the interdependence between sectoral and overall labour market conditions, as well as the potential contribution of the care sector to the development of good quality employment in Europe. Comparison between these two care regimes (see box 3) can well illustrate the question of the interdependence of care regimes and employment models for the quality of care work. Are conditions in care regimes, in particular liberal welfare regimes such as the UK, inherently unfavourable to the objective of achieving good working conditions? Which care regimes better sustain and promote good quality care and good working conditions, as defined by the EC (European Commission 2001)? Is the interconnection with employment models relevant?



Box 3. Job quality in care: Denmark versus the UK

The conditions associated with good quality employment in Denmark include:

- extensive *professionalisation* of the work, based on a coherent discipline (pedagogy) with strong historical roots and cultural identity
- extensive *unionization*, with trade unions having multiple roles – economic, professional, training and political.
- high levels of tax-based public *funding*, channelled directly into services
- a *welfare regime* which assumes a public responsibility to ensure widespread, and in some cases universal, access to services (Escobedo et al. 2002: 39-40)

Conditions in the UK are, in many respects, the antithesis of Denmark: low levels of professionalization, weak trade unions, lower public funding increasingly channelled to care recipients, a relatively small public sector with a large for-profit private sector, and a ‘liberal’ welfare regime which emphasises targeted public support and a norm of private responsibility. In the UK, the conditions of many care workers, already poor, may have deteriorated in the 1990s, because the restructuring of the welfare state, with increased privatisation of services, has led to processes of segmentation, deskilling and deteriorating employment conditions especially among workers in services for elderly people (Urwin and Rubery 2006).

Denmark has one of the highest levels of training of care workers, and the UK probably the lowest. The training for pedagogues (42 months at a higher education level) is roughly comparable with that for nurses (45 months) and social workers (36 months). Denmark also has a large body of social and health service helpers and assistants with a 1 to 2 year training¹. Conversely, in the UK the main education among workers in nurseries is a 2 year, post-16 training (a teacher, by contrast, has a 4 year, post-18 education at higher education level). Overall, according to the English Department of Health about 80 percent of the social care workforce do not have a relevant qualification for the job that they do....(Furthermore) levels of qualification within the social care occupations vary considerably. Thus, while 43 percent of social workers and probation officers hold a university degree, this is the case for just 3 percent of care assistants (UK national report, quoted in Ewijk et al. 2002: 37)².

¹ ‘Social and health service helpers and assistants’ (*social- og sundhedshjælpere og - assistenter*) are a particularly important group in Denmark. They are generalist workers located between helpers and nurses, providing domestic work (e.g. cleaning) and personal care. Compared to workers doing similar work in other countries, they are relatively well educated, with training between 14 and 20 months. This occupation means that there are very few untrained workers in services for elderly people: recent research suggests that less than 5 percent of workers with elderly people do not have at least this level of training (Ewijk et al. 2002: 67).

² It is argued in the Danish National report (quoted in Ewijk et al. 2002) that in Denmark workers in elderly care services have a higher level of education and training than in Sweden, where, unlike Denmark, only half of home helps are trained at an upper secondary level (although a goal has been set that all should be trained to this level). Overall, workers with elderly people have lower levels of training than workers with children and young people.

As it has been argued in section 1, highly diverse conditions in labour markets and care regimes will result in large cross-country differences in the division between family and market care as well as in the quality and conditions of care jobs. In liberal regimes there seems to be a greater risk of falling into what has been called “a vicious circle of unsatisfactory working conditions, continuing labour shortages and poor service quality” (NESY 2002, p.6). It is an open question, however, whether the



only means to achieve good quality employment in the care sector is for government to take a large and direct role as a provider of services, as in the Nordic welfare regimes (see also Simonazzi 2009).

2. *Shift to home care.*

Elderly care occupations are basically organised in a two tier structure (Ewijk et al. 2002:58 ff). In the home care sector, the first tier is composed of practical nurses who have some level of formal training. In some cases they provide personal care to the client, such as assistance with chronic health or mobility problems, while in others (Norway) they may supervise other carers. The second tier is composed of home helpers who provide clients with basic assistance in daily activities which may include personal care. Institutional settings employ a higher proportion of qualified carers who combine personal care and medical service because they deal predominantly with frail elderly people with more serious health and care problems. A study from the Netherlands describes a common pattern of institutional occupational structure: “old people’s homes frequently work with only two types of caring jobs which are of considerably different levels: the ancillary worker who mainly carries out household work and the carer who carries out caring, nursing and attendance duties” (quoted in Christopherson, 1997: 15, 25-26).

In eldercare, there has been increasing fragmentation of care work, with consequent specialization on the basis of skills. Although recent trends appear to indicate a more complex division of labour with personal, health care, and domestic assistance separated into different occupational categories where they had once been combined or at least demonstrated a great deal of overlap, the separation of these jobs has not led to the creation of a hierarchy of skills in a single but expanded occupation but instead to a segmented labour market. The function requiring the least formal qualification, domestic assistance, has been separated and assigned to workers who are at the periphery of the labour force (Christopherson 1997: 36). However, the shift to home care, and the consequent delay in institutionalisation, will require reorganisation of the entire care chain through redefinition of the services necessary to assist the elderly at home, reallocation of investment and infrastructure among hospitals, nursing homes, community services and (smart) houses, the skills required in each segment, the right mix of support services for home and community-based care. With health services more dispersed in the community, closer coordination between home care and home nursing activities will be necessary to guarantee the continuity of care and to assist the carer by means of the various support measures. At the other end of the care chain, with the average period spent in residential care decreasing, the share of residents with greater nursing and health needs will increase. This will require the ‘re-medicalisation’ of nursing homes so as to cope with the greater nursing and medical needs of residents (OECD 2005 p. 86), and the conversion of a large proportion of residential houses into nursing homes. This will entail change in their organisation and in their demand for skills, with effects on their costs and balance sheets. The other implication of the shift to home care is the increasing involvement of families, sustained by monetary subsidies and other support schemes (see Box 4 on the effects of the recent reform of the German long-term insurance). This will call for a whole set of new competencies to provide the families with information, organisation, support, counselling.

To conclude, the shift to home care changes the organisation of work and the skills required. Boundaries between settings are being bridged. The blurring of domestic and residential services for elderly people will affect occupations, making it increasingly problematic to locate their work within only one setting. More and more local authorities adopt an integrated scheme where the same staff work partly in ordinary houses and partly in centre-based ‘service flats’. In Denmark, for instance, it is difficult to distinguish home helps working in the homes of elderly people from those working in centres (Ewijk et al. 2002; Galca 2004). This raises the issue of the kind of competencies - specialised versus general - to be provided. It also raises the issue of coordination and governance of the whole care chain: not only health and social care, but also social services and



support schemes connected with the assistance of the main carer and her family (such as information, advising and counselling, respite care, and so on). These new trends may favour a more generalist workers, equipped with competencies encompassing many settings in the care work domain, who will adopt a holistic approach¹¹, and/or will work in closely coordinated team.

Box 4. The reform of long-term insurance in Germany: a further drift towards informal care

The Reform of the long-term care insurance took place on the 1st of July 2008. One outstanding feature of the care reform was its further strengthening of home care in contrast to institutional care, and, by extension, its further thrust to informal care.

- In the case of home care, both cash benefits and benefits in kind have been augmented for all the three care categories of dependence (considerable, severe and extreme need of care). Conversely, benefits have been increased only for the third category in the case of institutional care, .
- Informal carers: employees (in firms with at least 15 employees) with care obligations are now entitled to take time off for caring. They can apply on short notice for a 10 day break (short-term care), for instance when a care need has abruptly emerged, in order to organize things, get information and so on. There is also the possibility to get a 6-month period off. Employees have the right to resume a similar working place/position in the firm when the care period is over. During the break (both the short-term and the long-term one) employees will not be paid, but their social security contributions, pensions funds (minimum amount) and health insurance are paid. Moreover, informal carers who take vacation are entitled to receive pension funds during that period.

By strengthening the measures in support of reconciliation between work and family, the German government is not actively promoting a shift towards professional home care but it is aiming instead at reinforcing the cheaper informal care that falls mostly upon the female family carers. Thus, the German reform de facto assumes that the German welfare state will continue to rely on the informal care of women when it comes to the long-term sustainability of care for the elderly and it is not looking for new options. There is evidence that the share of persons being cared for only informally is increasing for the first time since the introduction of the long-term care insurance in 1995, reverting its descending trend (Statistisches Bundesamt 2008).

4.3 Cash for care: a support to undeclared care work?

The ultimate aim of the shift from institutionalised to home care is to strengthen families' caring capacities and transfer more weight onto informal care. In fact, home or community care (whether formal or informal) is considered to be far cheaper than institutional care, while responding better to the preferences of the elderly. With families at the limit of their care-giving capacity, monetary benefits and other non monetary support schemes are increasingly provided to care users and their families as support for their caring activities.

Cost considerations pushing in the direction of encouraging and supporting a greater role of family care may run counter to other economic and social trends/goals pushing in the opposite direction. Demographic developments, changing family structures, and women's drive for emancipation and higher participation in the labour market will give rise to an increase in the demand for formal long-

¹¹ For example, a multi-disciplinary generic profession for working with adults which brought together skills from various other professions (e.g. physio-therapy, social work, pedagogy and nursing).



term care services. Governments may be caught between two apparently conflicting goals: a higher female activity rate and a greater reliance on home care. The impact of these policy changes on the division between formal and informal care, on the one hand, and care-giving and female employment on the other, may vary widely across countries with care regimes and labour market models. Here, however, we are concerned with the effect on the organisation of the care sector and the effects on care work. Can funding based on monetary subsidies support good quality employment, and if so at what conditions?¹²

The various European countries differ widely in their conditions regulating cash transfers for care, such as those who are entitled to the transfer and how it must be spent. The range varies from freely disposable monetary transfers that can be treated by families as income support (as is the case of the dependence allowance in Italy and Austria) to tightly controlled benefits conditional upon the employment of regular paid carers (as in the case of France, Belgium, or the Netherlands) (Ungerson 1997; Ungerson and 2007). We can distinguish different country patterns (table 8).¹³ On the one hand we have countries (such as France and the UK) that are more restrictive in the use of monetary transfers to pay the family carer. In France vouchers are provided to families for the direct recruitment of paid care workers. In the UK direct payments are a relatively recent experience; it is a highly regulated scheme aimed at enhancing the elderly person's freedom and independence (Yeandle and Stiell 2007: 128). At the other extreme lie the Mediterranean and the Bismarckian countries. In Italy both the state and families perceive the various allowances as forms of income subsidy that can be freely used to complement the family budget. In spite of the institution of a long-term care insurance, Germany and Austria more closely resemble the Mediterranean countries with regard to its use. In both cases, the LTC insurance started from the premise that home care should take precedence over care in nursing homes. Hence the allowance was by no means intended to reduce the quantity of care provided informally. The idea was instead to make caring more attractive, so that caregivers, especially women of working age, would continue to care rather than enter the labour market (Morel 2007:15-16; Box 4)¹⁴. In the Netherlands, where elderly-care was mainly institutionalised, a new policy taking the form of a 'Personal Budget', entitles dependent people to a care allowance to be used for the purchase of care services, whether informal (from relatives) or professional. The introduction of this benefit is part of a move towards providing care recipients with greater freedom in deciding how best to service their needs. It is also, as in other countries, a way to offer some form of remuneration to informal carers (Morel 2007:19). By contrast, other countries (such as France and Belgium) resorted to tied cash benefits with the primary aim of integrating low skilled women into the regular labour market, while responding to the increasing need for care. Finally, in the Scandinavian countries cash benefits are still very limited. However, since the Adam reform of 1992, Sweden has targeted its care provision more strictly to health care needs (as opposed to personal care services) and to the most dependent among the elderly persons. As correspondingly more support is required from families, various forms of support and monetary compensation have been introduced. However, together with Finland, Sweden is the only EU country to have set the monetary compensation for the family carer at the same level of pay that is earned by a public employee in the care sector (Ciarini 2007).

The differences in the conditions regulating cash transfers may have large effects on the quality of care work (Simonazzi 2009a). Monetary transfers affect the care-employment trade-off through

¹² Two different perspectives confront themselves on the issue of payments for care: one views them as leading to a potentially positive transformation of care provision, the other underlines the risks deriving from the revival of domestic service, and the potential worsening in the working conditions of carers, the exploitative pay for 'women's work', further gender segmentation and the growth of an unregulated, 'grey' labour market (Ungerson 1997).

¹³ See Simonazzi (2009a) for a more detailed description of the various systems. See also Ungerson and Yeandle (2007) for an overview of the various cash-for-care schemes.

¹⁴ Since the carer can simultaneously work in a so-called Mini-job, it is evident that the German way of cash allowances can exert a strong incentive for women to reduce working hours or to stay out of the core labour market.



income and substitution effects, but they may have different effects on the formal/informal division of care according to the conditions regulating their disbursement and utilisation. Tied monetary transfers (e.g., vouchers) reduce the market price of care and make paid care more affordable, thus encouraging the creation of a formal market (which, in turn, may or may not entail good working conditions). Conversely, untied cash payments soften the budget constraint leaving the relative cost of formal to informal care unaffected. They thus provide a support for family income that may or may not be used to hire formal or informal carers. The effect can be either an increase in the “informal”, but subsidised, family care, with possible negative effects on female labour market participation; or an increase in the demand for paid care (subsidised market demand). When the latter is the case, unconditional monetary transfers may encourage the development of a particular form of home-based, often irregular, low-paid care generally accessed privately through the market (as is the case of the female immigrant carers in the Mediterranean countries, in Austria, and increasingly in Germany).

The amount of the subsidy is clearly a crucial factor. Given their generally low levels, cash allowances are unlikely to be the decisive factor in freeing up unpaid carers to participate in the labour market. They are more likely to be considered as an income subsidy which rewards previously unpaid carers or subsidizes the cost of formal carers. However, when combined with other sources of income, such as the dependent elderly’s pension, unconditional cash allowances can help in meeting the cost of paid care. In the case of untied monetary transfers, a flat rate subsidy will be most effective in discouraging the market participation of women on low incomes, since even a low subsidy may compare not too unfavourably with the wage that they could earn on the market. The flexibility of working times, the possible wage penalty related to caring obligations, the need to resort to some form of paid care, combined with the likely old age of the carer, are likely to tilt the choice in favour of care-giving. Re-entering the labour market after the care-giving has concluded obviously becomes very difficult. For lower-middle income families, conversely, the subsidy may be decisive in turning the choice in favour of buying the services in the market. A large availability of cheap care labour, combined with unconditional cash allowances, can open the market opportunity also to a large share of lower-middle income families even at relatively low levels of subsidies.

All things considered, cash transfers are unlikely to be the key factor capable of changing the trade-off between care and paid work, but they may affect the care labour market by favouring the emergence of a low-pay, largely irregular supply of paid carers (Simonazzi 2009). Systems relying on in-kind provision (Sweden), contracting-out (the UK), and ‘tied’ cash allowances to be used to hire private carers (France) favour the formation of a formal and regular care labour market. Systems relying mostly on unconditional cash allowances (the Mediterranean countries, Austria and Germany) favour the informal market. In Austria, cash benefits, coupled with little regulatory oversight, a tradition of home care, the permeability of the country’s Eastern borders (due also to historical ties) have encouraged a large inflow of migrant carers, many of whom are illegal but are openly recruited by agencies for short-term, rotating care duties (Hermann 2006). In Germany, in spite of the prevalence of unconditional cash benefits, reliance on illegal foreign workers does not yet seem to have reached similar proportions (Kuemmerling 2006). In regard to the Mediterranean countries, the limited amount of public involvement in care financing explains their failure to develop a formal private market of paid care for older people and the dominance of individual suppliers. The unconditional character of monetary transfers, in an unregulated labour market with a large grey economy, has led to the development of a large supply of irregular, often undocumented, immigrant carers to fill the gap in the supply of affordable care workers. We may conclude that cash for care schemes largely reflect the characteristics of care regimes, ending up by reinforcing their effects in terms of the division of care labour between formal and informal care and of the quantity and quality of care work. Thus, the conditions regulating the trend towards subsidised home care



may have important consequences for the future sustainability of the various care regimes and for the quality of care work.

The flow of cheap, legal carers since EU enlargement is changing the features of care regimes and care labour markets across Europe. We may envisage two possible outcomes. The first is an increase in the supply of cheap, regular labour, possibly on a temporary basis, in those countries where the formal care market predominates, as in the UK, France, possibly Sweden. The second outcome concerns those countries which rely on untied monetary transfers or which have large informal markets. Here, greater freedom of movement within the enlarged Europe may have the effect of fuelling the informal/irregular market for care. In Germany and Austria, reforms aimed at dealing with the financial difficulties of their insurance schemes will be decisive in determining in which direction the care regimes of these two countries will move: whether towards greater recourse to immigrant carers but on a formal basis, or towards the Mediterranean model with its reliance on irregular migrant carers¹⁵. The latter's capacity to move towards a more regulated care market will depend very much on how the cash benefits are disbursed and on the conditions regulating the formal and informal care markets.

5. Conclusions: the future of care work status (and pay)

The health and social service sectors was responsible for almost one in every five jobs created across the EU between 1995 and 2001. Since the rate of growth of demand is predicted to continue in the future it is important to devise adequate measures and reforms to avoid the formation of a huge care labour shortage. Care work suffers from a poor standing, with training, pay and other employment conditions often poor. The first step is thus to improve the working conditions of those already in the market, and to address the issues of high staff turnover by making the care sector a more attractive career option. Although efforts have been made in this direction, much still remains to do.

Two broad conclusions can be drawn from the analysis carried out in this report. First, the quality of care work is correlated with the quality of the overall labour market. Labour market policies aimed at improving the quality of employment will affect also the care sector. Second, the quality of care work is tightly connected with policies aimed at reducing the devaluation of female work, and of unpaid care work in particular. Unpaid care work is seen as a devalued activity, something that women are considered to be inherently equipped to do: this perception carries over into paid care work. The lack of status is complemented by the widespread perception that education and training are not required. The attainment of high quality employment in the care sector requires to overcome these broader barriers. This explains why, in a comparative perspective, care labour quality is higher in those countries whose care and employment models have progressed the most in both these directions. Within a more favourable framework, policy measures aimed at increasing the education attainment of workers, to provide training and certificates, to ensure a career, will be most effective in retaining old employees and in attracting new ones into the sector (unemployed, elderly people, migrants, new graduates, men as well as women).

The reorganisation of the care sector that is underway in all the EU countries will open new career opportunities; the increasing integration of the care sector with the social and health sector, its increasing reliance on IT, the increasing fragmentation of the care chain will require new competencies to bridge these various domains. However, important implications may derive to care work and to the care worker from the common trends that are changing the main features of the care regimes and from the way in which care reforms are implemented in the various countries. In the process of contracting out care services, as well as in the case of 'customer-provider' relationship based on a cash nexus (in which the power relationship shifts to the 'customer'), the public

¹⁵ The last reform in Germany is but the first step: the next financial squeeze is expected in 2013.



authority needs to retain the governance of the social market, in order to maintaining control over quality of care and quality of care work. Working conditions (and quality of care) may be more difficult to safeguard when, as in the Mediterranean countries, families act as employers in a largely informal market. In this case too, the public authority can exert control by attaching conditions to the granting of allowances. To conclude, policies for better jobs need to be coordinated with policy reforms in the care sector, to prevent that short-sighted reforms, urged by financial reasons, end up in worsening the average work quality and long-term sustainability of the elderly care market.



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STATISTICAL ANNEX



TABLE 1. EMPLOYMENT TRENDS BY INDUSTRY. EU-25

Levels (000s)	1996	2001	2006	2010	2015
Agriculture, etc.	12 230	11 096	9 753	8 690	7 764
Mining and quarrying	1 005	724	651	572	500
Food, drink and tobacco	5 012	4 987	4 781	4 743	4 632
Engineering	7 943	8 096	7 502	7 660	7 542
Rest of manufacturing	24 847	24 214	22 588	22 852	22 241
Electricity, gas and water	1 817	1 626	1 514	1 404	1 364
Construction	13 729	14 514	15 141	15 598	15 583
Distribution	28 945	31 127	32 153	33 042	34 031
Hotels and catering	7 891	9 158	9 932	10 801	11 547
Transport & telecommunications	11 520	12 280	12 157	12 235	12 162
Banking and insurance	5 743	6 028	6 014	6 040	6 032
Other business services	17 424	23 308	26 140	29 196	33 079
Public admin. and defence	13 837	14 157	14 258	14 336	14 432
Education	12 896	13 693	14 507	14 927	15 574
Health and social work	17 020	18 545	20 081	20 911	22 005
Miscellaneous services	10 855	12 292	13 485	14 390	15 448
All industries	192 714	205 844	210 656	217 399	223 936
Shares (%)	1996	2001	2006	2010	2015
Agriculture, etc.	6.3	5.4	4.6	4.0	3.5
Mining and quarrying	0.5	0.4	0.3	0.3	0.2
Food, drink and tobacco	2.6	2.4	2.3	2.2	2.1
Engineering	4.1	3.9	3.6	3.5	3.4
Rest of manufacturing	12.9	11.8	10.7	10.5	9.9
Electricity, gas and water	0.9	0.8	0.7	0.6	0.6
Construction	7.1	7.1	7.2	7.2	7.0
Distribution	15.0	15.1	15.3	15.2	15.2
Hotels and catering	4.1	4.4	4.7	5.0	5.2
Transport & telecommunications	6.0	6.0	5.8	5.6	5.4
Banking and insurance	3.0	2.9	2.9	2.8	2.7
Other business services	9.0	11.3	12.4	13.4	14.8
Public admin. and defence	7.2	6.9	6.8	6.6	6.4
Education	6.7	6.7	6.9	6.9	7.0
Health and social work	8.8	9.0	9.5	9.6	9.8
Miscellaneous services	5.6	6.0	6.4	6.6	6.9
All industries	100.0	100.0	100.0	100.0	100.0

Source: Cedefop 2008: 91



TABLE 2. EMPLOYMENT TRENDS BY OCCUPATION. EU25

Levels (000s)	1996	2001	2006	2010	2015
01 Armed Forces	1 245	1 197	1 215	1 197	1 165
11 Legislators and senior officials	484	603	495	531	596
12 Corporate managers	8 349	9 294	9 920	11 032	12 346
13 Managers of small enterprises	6 561	6 436	7 990	8 071	8 135
21 Physical, mathematical and engineering science professionals	5 518	5 995	6 401	6 944	7 452
22 Life science and health professionals	3 698	3 345	3 551	3 602	3 658
23 Teaching professionals	7 862	8 057	8 464	8 595	8 736
24 Other professionals	7 143	8 086	8 933	9 927	11 265
31 Physical and engineering science associate professionals	6 911	7 666	7 715	7 927	8 129
32 Life science and health associate professionals	4 807	5 559	5 618	5 671	5 800
33 Teaching associate professionals	2 126	2 408	2 606	2 874	3315
34 Other associate professionals	13 799	16 100	18 013	19 626	21446
41 Office clerks	20 840	20 891	18 795	18 075	16944
42 Customer services clerks	3 792	4 198	4 522	4 758	5100
51 Personal & protective services workers	15 408	17 497	18 848	20 154	21361
52 Models, salespersons and demonstrators	9 977	11 221	10 642	10 611	10656
61 Skilled agricultural and fishery workers	9 829	8 960	7 789	6 817	6082
71 Extraction and building trades workers	11 205	11 657	12 597	12 851	12718
72 Metal, machin. & related trades workers	11 976	11 646	10 466	10 264	9555
73 Precision, handicraft, craft printing & related trades workers	1 865	1 614	1 444	1 298	1171
74 Other craft and related trades workers	5 595	4 975	4 338	4 237	3977
81 Stationary plant and related operators	2 034	2 081	2 103	2 060	2079
82 Machine operators and assemblers	6 622	6 961	6 498	6 588	6596
83 Drivers and mobile plant operators	8 414	8 262	8 713	8 991	9175
91 Sales & services elementary occupations	10 408	14 092	15 568	17 095	18630
92 Agricultural, fishery & related labourers	1 269	1 197	1 249	1 163	1116
93 Labourers in mining, construction, manufacturing and transport	4 978	5 848	6 163	6 440	6 735
All occupations	192 713	205 844	210 656	217 399	223 936

Source: Cedefop 2008: 93



TABLE 3. ELDERLY CARE REGIMES IN THE EU, END 1990s

Country groups	Northern Europe Beveridge-oriented	Continental Europe Bismarck-oriented	Mediterranean Countries	Central-Eastern European countries
Characteristics	State responsibility for dependency through social and health services funded from general taxation	Dependency as a new form of risk, to be covered through a new form of insurance or universal cover	Based on a principle of social assistance	Families legally or implicitly bound to care
Countries (selection)	Sweden, UK, Ireland, Denmark, Finland	Germany, Austria, France, Luxembourg	Greece, Italy, Spain, Portugal	Hungary, Poland, Bulgaria

Source: Simonazzi 2009



TABLE 4. QUALIFICATION OF EMPLOYEES WORKING IN ELDERLY CARE. GERMANY 1999 AND 2007

Share of /year	Home care services (in %)		Nursing homes (in %)	
	1999	2007	1999	2007
Exam. Elderly care workers	13.9	19.0	19.0	23.4
Exam. Nurses	34.4	36.2	11.4	11.4
aids	7.9	7.3	9.1	8.3
Academic degree in care	0.2	0.8	0.2	0.6
No health care/elderly care training	17.5	15.7	24.4	23.6
unskilled	11.3	6.4	24.1	18.0

Note: The missing category: “others, such as physiotherapists, family workers, community workers” makes up to 100%.

Source: Pflegestatistik des Statistischen Bundesamt, 2001-2008.


TABLE 5. Total number of employees in care occupations according to the ISCO classification, 2000 (in 1000)

code	AT	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	NL	PL	PT	SI	SK	FI	SE	UK
223	NA	118,3008	NA	NA	8,5127	NA	NA	39,0485	0,86639	152,4641	NA	NA	1,91148	3,48457	2,71504	0,13191	2,89834	60,01671	NA	NA	NA	NA	69,42655	43,15833	528,687
323	84,32236	5,59215	50,34466	93,82513	48,54587	774,434	8,96011	1,65733	34,81637	NA	406,978	337,4945	0,56737	10,37388	27,37136	2,75141	44,99501	201,4572	235,1371	0,03678	12,07835	52,90562	73,31224	60,14099	126,651
346	26,04709	NA	2,61565	8,11433	13,15442	348,3415	NA	6,43526	2,60894	28,55947	236,785	58,8239	0,06425	1,97105	0,38743	0,28312	12,17936	54,42948	17,67815	NA	NA	0,96744	6,12896	31,82832	266,037
513	48,62153	83,03117	36,77564	28,41968	199,6087	793,3319	5,52404	35,69753	37,69555	329,089	1279,662	239,2395	1,81877	11,86982	14,07355	2,30692	34,69741	222,3371	87,55821	110,5844	4,95676	20,77545	72,28101	423,9592	1149,567
913	178,746	98,97341	78,72568	120,9611	108,4289	990,1751	21,11461	36,2595	110,4002	802,3709	1095,102	509,6589	17,40332	27,14379	60,84321	13,98535	120,0203	252,0514	433,5404	271,3672	23,35097	64,88074	76,00695	55,613	896,031
Total	337,7369	305,8975	168,4616	251,3202	378,2506	2906,282	35,59876	119,0981	186,3875	1312,484	3018,527	1145,217	21,76519	54,84311	105,3906	19,45871	214,7905	790,2918	773,9139	381,9883	40,38608	139,5293	297,1557	614,6999	2966,973

Source: ISCO database of SEGREGAT

TABLE 5b. Share of care workers in total employment, 2000

occupational category/ countries	AT	BE	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	NL	PL	PT	SI	SK	FI	SE	UK
nursing and midwife professionals	NA	2,89%	NA	0,31%	NA	NA	2,34%	0,02%	0,98%	NA	NA	0,66%	0,41%	0,19%	0,05%	0,08%	0,77%	NA	NA	NA	NA	2,95%	1,04%	1,90%
nursing and midwife associate	2,23%	0,14%	1,98%	1,78%	2,12%	1,57%	0,10%	0,85%	NA	1,70%	1,59%	0,20%	1,23%	1,96%	1,04%	1,17%	2,58%	1,62%	0,00%	1,35%	2,52%	3,11%	1,45%	0,46%
social workers associate	0,69%	NA	0,17%	0,48%	0,95%	NA	0,39%	0,06%	0,18%	0,99%	0,28%	0,02%	0,23%	0,03%	0,11%	0,32%	0,70%	0,12%	NA	NA	0,05%	0,26%	0,77%	0,96%
personal care	1,29%	2,03%	0,60%	7,33%	2,17%	0,96%	2,14%	0,92%	2,12%	5,36%	1,13%	0,63%	1,41%	1,01%	0,87%	0,90%	2,85%	0,60%	2,20%	0,55%	0,99%	3,07%	10,19%	4,14%
domestic and related helpers	4,73%	2,42%	2,56%	3,98%	2,71%	3,69%	2,17%	2,69%	5,17%	4,59%	2,40%	6,03%	3,21%	4,35%	5,30%	3,12%	3,23%	2,98%	5,39%	2,61%	3,09%	3,23%	1,34%	3,22%
total	8,94%	4,58%	5,31%	13,58%	7,94%	6,22%	4,79%	4,53%	7,48%	12,64%	5,40%	6,88%	6,08%	7,35%	7,33%	5,50%	9,36%	5,33%	7,59%	4,52%	6,64%	9,67%	13,74%	8,77%

Source: ISCO database of SEGREGAT



TABLE 5c. Share of population over 65 per care sector employee

AT	3,6
BE	5,6
BG	7,9
CZ	5,6
DK	2,1
DE	4,6
EE	5,8
IE	3,5
EL	9,6
ES	5,1
FR	3,2
IT	9,0
CY	3,6
LV	6,4
LT	4,6
LU	3,2
NL	2,7
PL	6,0
PT	3,9
SI	6,8
SK	4,4
FI	2,6
SE	2,5
UK	2,8

Source: ISCO database of SEGREGAT and Eurostat



Table 6. Total employment in the elder care sector

	Germany (2003)	England ¹ (2003/4)	Sweden 2004	Austria 2002	France	Italy 2004	Greece 2001	Spain 2003
Home/Domiciliary care	200,897	(163,000)		3,400 ²	800,000 ³	30,000		
Nursing homes/ Residential care	510,857	(462,000)		16,963	134,000 ²	125,000		
irregular workers (estimates)	(100000)			(40000)		(500,000)	⁴	(50000)
Total	711,754	625,000	239,500	20,636	934,000	655,000	21,325 ⁴	150,000 ⁵
Population >65 per employee ⁶	20.9 (18.3)	12.5 ¹	6.4	61.1 (20.8)	10.7	88.9 (17)	92.7	47.7 (35.8)

Notes:

¹ The estimated figure for the UK is 12.6.

² Full-time equivalent. In the case of Austria, the number of employees in home care may be three times higher, because most home care workers work part-time.

³ Registered as domestic workers, not all of them are working with the elderly.

⁴ Total employment in the social care sector. According to the 2001 Population Census, migrants account for 20.5% of total workers employed in the provision of services to households.

⁵ The total includes 25,000 workers employed in Social Services Centres. The figure of 50000 is likely to underestimate the actual number of irregular immigrant employed as elderly carers; in fact 200000 immigrants benefiting from the 2005 amnesty were working as domestic workers (though not all of them necessarily caring for elderly people).

⁶ The ratio including estimated irregular carers in parentheses.

Source: Simonazzi (2009).



Table7. Employees in elderly care (1999-2007) – home care and nursing homes, Germany

	Home care					Nursing homes				
	1999	2001	2003	2005	2007	1999	2001	2003	2005	2007
Numer of employees total	183782	189567	200897	214307	236162	440940	475368	510857	546397	573545
%	Of which					Of which				
Full-time employees	31.0%	30,3%	28,6%	26,3%	26,4%	48,0%	46,0%	42.4%	38,1%	35,4%
Part-time	42.4%	45,3%	46,5%	48,2%	48,4%	35,3%	38,3%	41,4%	44,1%	47,0%
Marginal employees	21.3%	19,7%	21,2%	22,4%	22,5%	9.7%	9,3%	9,6	10,1	10,2

* Internships, (compulsory) community service (not reported) make up to 100%.

Source: Pflegestatistik des Statistischen Bundesamt, 2001-2008.



Table 8 Family eligibility and conditionality of monetary transfers

	Mediterranean/ Familialistic	Continental/ Bismarckian			Anglo- Saxon	Nordic
	Italy	Austria	Germany	France	UK	Sweden
Spouse	yes	yes	yes	no*	no	nr
Other kin	yes	yes	yes	no	no	
Use of transfers yearmarked?	no	no	**	yes	yes	nr

* Family members can be paid if officially unemployed.

** The cash payment is subject to the definition of a care plan.

Nr = not very relevant, but on the rise.

Source: Simonazzi (2009b)



Figure 1. Share of care workers in total employment, 2000

