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Changing care services and labour markets

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1. Executive Summary

The provision of social care is one of the most important issues facing European countries. Changing demographic structures, local labour markets, migration policies and systems of financing social services all influence social care provision. The role of informal care continues to play a central role in care provision.

National social expenditure, as measured by the percentage of Gross Domestic Product, increased from 1980 to the mid-1990s but declined after 1995, in many European countries. Since 2000, there has been some slight increase. The majority of European countries spend over 20% of the value of their GDP on social expenditure, which includes a range of expenditure, for example, pensions, social security benefits, and residential and home care services.

Care provision in Europe

The European Commission estimates that the number of people between 65 and 79 living in the European Union will grow by 37% between 2010 and 2030. There have already been extensive changes taking place in the financing of care and the support for carers, which affect the demand for care from public, private and NGO providers. These changes have also led to the development of new occupations and roles in social care.

A recent survey (Pommer et al., 2007) of care needs, as defined by levels of disabilities, in the over-50s population, found that 32% of the over-50s in Europe suffered some form of impairment. These rates are higher in Mediterranean countries and lower in Nordic countries and the Netherlands. Access to an informal network reduces the chance of receiving formal care, in all countries. This is a very significant finding because care provision, in all countries, is strongly dependent on informal care provision.

France, Italy, Poland and the UK provide care allowances, which enable a person needing care to buy specific care services. In France, this allowance is known as the Personalised Autonomy allowance. In Italy, home care vouchers are available for older people needing care. In the UK, direct payments for care services are available to people with high levels of disabilities. In Spain, a new social care law has also introduced new individual rights and responsibilities for care services.

There has been an expansion of child care during the 1990s and this trend continues. However, there are wide variations between countries, which are influenced by the period in which child care provision has expanded. This is also influenced by the participation of women in the labour force.

The European Union (EU) has recognised the need to improved access to childcare as part of its European Employment Strategy to expand the percentage of women in the workforce (Barcelona Council, 2002). The EU focus on child care provision is also related to falling birth-rates and the recognition that good quality child care is a factor in determining decisions about family size and in achieving a sustainable work-life balance (Blackburn, 2006).

Cross border mobility

Between 1995 and 2001, 2 million jobs were created in health and social care services, 18% of the total jobs created (European Foundation, 2006). In addition, low pay, the poor image of care work and poor training opportunities as contributed to dampening the latent demand for care services. In many countries, the care sector faces a shortage of labour and is unsuccessful in attracting younger workers.

Increasingly EU and national migration policies are having a major influence on the social care labour market. There have been significant increases in inflows of foreign workers, into many countries of the European Union, over the past decade, although their contribution to the overall labour force varies.

In Belgium, Germany, Greece, Netherlands, Norway, Sweden, Switzerland and the UK over 10% of health and community services workers are foreign born (Dupont, 2006). Although the term 'foreign born' can cover workers who have been resident in a country for much of their lives, these figures give some impression of how health and community services depend on foreign-born workers.

Training and registration

The registration and accreditation of social care workers is less advanced than in child care. Child care is often associated with an element of pedagogy and this has raised the expectations of the standards of

child care workers. Minimum qualifications for child care are higher than for social care. Nordic countries have higher standards for both social and child care workers. Greece and the UK have recently introduced new social work degrees.

One of the goals of registration is to make care work more appealing to younger people. A crucial factor in developing training for care workers is whether the training provides opportunities to enter similar professionals, such as nursing or social work. Not all countries have achieved this synergy between different types of training. This will influence whether younger people are interesting in training to be care workers.

Volunteers

Volunteers are part of the non-paid care workforce who, along with carers from the family and non-kin carers, provide informal care. Informal care plays a central role in care provision. The impact of volunteers on working conditions and the professionalisation of care work, is influenced by the role that volunteers play in European societies. There are different national traditions of volunteering and voluntary organisations provide different contributions to local and national care sectors. Similarly, the national profile of volunteers also varies, with different age groups active in different countries. The potential of volunteers to undercut paid care workers, also has to be considered in the context of the extensive amount of informal care provided by women, throughout Europe.

Collective bargaining

There are new developments in collective bargaining that are drawing the private and not for profit into formal agreements. This reflects the growing role that these sectors play in the provision of care services. The existence of active umbrella organisations that can represent the interests of care providers is essential for the development of sectoral agreements.

Countries in Eastern and Central Europe are successfully negotiating higher annual pay increases than in many Western European countries, although they are starting from a low wage levels.

Changes in the nature of funding, in the care sector, are influencing the development of a social care labour market. Migration plays a role in ensuring the provision of care workers in many European countries. Countries will continue to face problems in recruiting care workers because of the low status of the sector and an ageing workforce. Changes in training and registration aim to raise the profile and status of the sector but these will only gradually change the way that the sector is viewed by younger people. The continued importance of informal care is gradually being recognised as an important factor in shaping the formal care sector.

2. Changing care services and labour markets

The provision of social care is one of the most important issues facing European countries. Changing demographic structures, local labour markets, migration policies and systems of financing social services all influence social care provision. The policy contexts, within which decisions that influence social care provision are taken, are increasingly interlinked. The role of informal care continues to play a central role in care provision. Demand for social care is expected to increase and many countries are developing new ways of delivering care. The demands for an expansion of care provision, are also creating pressures for improved standards of care delivery, which are being addressed through training and new systems of registration.

In 1996, the Turin Social Charter of the Council of Europe agreed to establish the right to social services as mandatory. In the 1st EU Convention (2000) and the draft European Constitution (2003) this mandatory right was abolished, as it was for the right to social assistance. This indicates the although the demand for social care services in Europe will continue to expand with an ageing population, the rights to social services and social assistance can not be assumed to be protected in future.

The patterns of national social expenditure, as measured by the percentage of Gross Domestic Product, increased from the period 1980 to the mid-1990s but declined after 1995 in many European countries. Since 2000, there has been some slight increase. There are also some significant differences in the percentage of GDP spent on social expenditure between countries

in Europe. The table below shows some of national differences, although the majority of European countries spend over 20% of the value of their GDP on social expenditure.

Table 1: Social expenditure as percentage of GDP

% GDP social expenditure	Over 30%	26-29%	20-25%	10-19%
Countries	Sweden (31.3%)	France 28.7 Denmark 27.6 Germany 27.3 Belgium 26.5 Austria 26.1	Norway 25.1 Italy 24.2 Portugal 23.5 Finland 22.5 Czech Republic 21.2 Netherlands 20.7 UK 20.6 Spain 20.3	Iceland 18.7 Slovak Republic 17.3 Ireland 15.9%

Source: OECD, 2003 www.oecd.org

The term gross social expenditure covers a wide range of types of expenditure covering pensions, social security payments, unemployment benefits, family benefits and allowances as well as expenditure on residential and home care provision for older people, children and people with disabilities. It is difficult to separate out the expenditure for residential and home care provision.

This paper will focus on several issues that influence the social care labour market and have long term implications for the development of the European care sector. It will begin with an overview of changes taking place in the delivery of care in different European countries. The paper seeks to address several research questions:

1. What is the extent of cross-border mobility of workers delivering social care services within Europe?
2. To what extent is registration of social care workers changing the nature of social care work, by country?
3. What is the impact of volunteers on working conditions and the professionalisation of social care work?
4. How are collective bargaining arrangements for social care workers changing across Europe?

Data for this paper has been collected from published sources of statistics, e.g. OECD, Eurostat, as well as published research from academic, government and non-government agencies. The EPSU Collective bargaining database was used as source of data about collective bargaining agreements affecting social services workers. Reports by the European Foundation of Living and Working Conditions on social care as well as EU funded research into social care and childcare work have also been used as sources of material.

3. Changes in social care provision in Europe

The European Commission estimates that the number of people between 65 and 79 living in the European Union will grow by 37% between 2010 and 2030. This is a sign of an ageing population, which will bring demands for different types of care delivery. There have already been extensive changes taking place in the financing of care and the support for carers, which affect the domestic demand for care from public, private and NGO providers. These changes have also led to the development of new occupations and role in social care.

Policy changes have also led to changes in the relationship between formal and informal care. Women still predominantly provide informal and formal care throughout Europe. These changes need to be considered in relation to the participation of women in the workforce, in different countries.

Pommer et al (2007) present a view of social care in Europe, which tries to identify needs, as defined by levels of disabilities, in the over-50s population. This is in contrast to many surveys which look at patterns of provision. Their survey found that 32% of over-50s in Europe suffered some form of impairment – physical (24)%, psychological (13%) or cognitive (10%). These rates are higher in Mediterranean countries and lower in Nordic countries and the Netherlands. Rates of physical disabilities increase with age and lower educational levels also lead to higher rates of cognitive impairment (Pommer et al, 2007:110).

This research found that 80% of over-50s had access to an informal social network. As people become older, their access to an informal network is reduced. In addition, the potential of an informal network to deliver informal care depends on the level of disabilities and employment status of people in the network. There were national differences in levels of access to informal care. In France, older people have less access to care both in and outside the household. In Denmark and Austria, there is less informal care available in the household. In Spain and Italy older people still have access to extended family networks because children remain living at home longer. These different levels of informal care are often related to the level of participation of women in the labour force.

Older people with disabilities in France, Netherlands and Denmark receive higher proportions of formal care. Netherlands and Denmark have higher levels of institutional and home care, whereas France has high levels of home care. The Netherlands has lower levels of informal care and higher levels of formal care. The survey found that access to an informal network reduces the chance of receiving formal care, in all countries. This is a very significant finding because care provision, in all countries, is strongly dependent on informal care provision.

The case of the Netherlands shows how recent changes in legislation have affected care provision. The modernisation of the Exceptional Medical Expenses Act (AWBZ) in 2000-2003, which encourages people to live in their own homes for as long as possible, will only reimburse the direct of costs of care for people with disabilities. The individual pays for the costs of housing and home care. This has had an impact on the families of people with disabilities, because people living in the same household have been expected to provide informal care (Pommer et al 2007). People can only apply for additional care when the need for care is 'prolonged' and informal resources are not available. The government only has the responsibility for providing care for those unable to support themselves.

A new law in the Netherlands, the Social Support Act, which also changes individual responsibilities for care, was introduced in January 2007. The underlying principle is that every citizen is personally responsible for their own care and for the care of their family/ friends. This Act puts the municipality in charge of social care services but does not oblige the municipality to provide certain types of services (Floris de Boer, 2006). This new arrangement of social care has implications for the expected provision of informal care.

Care is also provided through the provision of cash for care, which is given to the individual requiring care. France, Italy, Poland and the UK provide care allowances. In France, it is known as the Personalised Autonomy allowance (*Allocation Personallisee d'Autonomie* APA). In Italy, home care vouchers are available for older people needing care. In the UK, direct payments for care services are available to people with high levels of disabilities. Older people are expected to be eligible for direct payments in future. In Spain, a new social care law has also introduced new individual rights and responsibilities for care services.

In Austria, a care allowance for people with long term care needs was introduced in 1993. There is little long term care provision for older people 3,8% of people aged over 60 live in institutions

and 3.0% receive home care services. The introduction of a care allowance has led to the development of a fragmented system of care services with different providers, different form of provision and different regulations in relation to access and finance (Schiffbaenker and Kraimer, 2003). In most cases social services provide additional care and informal care is still essential.

Changes in the way that care is funded have also led to the expansion of types of care worker in Europe (European Foundation, 2006). As well as care workers employed by the public, private or voluntary sectors, there are '*independent*' formal carers, who are registered with an employment agency, for short term placements. Job security and wages are often poor. A third category, 'personal assistant' carers, who are recruited by the care recipient or recipient's family, may be permanent, short term or live-in.

There are also several categories of non-waged carers. Non-governmental-organisations (NGOs) and voluntary organisations use volunteers to provide services. The hours that they provide can vary from a few hours each month to a few hours a day. Volunteers are often paid expenses and given some basic training. Family informal carers provide care for family members. In some countries, for example, Sweden and the UK, there is a carers' benefit scheme. Non-kin carers also provide care to individuals (European Foundation, 2006)

Child care

There has been an expansion of child care during the 1990s and this trend continues. However, there are wide variations between countries, which are influenced by the period in which child care provision has expanded.

The European Union has recognised the need to improved access to childcare as part of its European Employment Strategy to expand the percentage of women in the workforce. The Barcelona European Council targets aim to provide, by 2010, childcare services for 90% of children between three years of age and the mandatory school age, and for 33% of children under three years of age (Barcelona Council, 2002). The EU focus on child care provision is also related to falling birth-rates and the recognition that good quality child care is a factor in determining decisions about family size and in achieving a sustainable work-life balance (Blackburn, 2006).

The Nordic countries established a public system of childcare by the 1970s, which is related to the expansion of women's participation in the labour force. The UK has been developing a much more mixed system, since the 1990s. The largest investments are in pre-school age care. Except in Denmark and Sweden, the pre-school age care is more developed than care for 0-3 year olds, which is more likely to be small scale, and informal (Blackburn, 2006). There are also trends in some countries, for example, Germany, for unemployed people to be denied access to free child care, often making it more difficult to access the labour market.

Although there has been an expansion of private or not-for profit child care providers, governments are increasingly involved in contributing to the cost of childcare. This may be through giving parents child care allowances through the taxation system, by providing child care vouchers directly to parents, by direct child care provision, or by contracting private providers. The type of system that is used to reimburse private child care providers can influence the pressure to cut costs. Contracts are often awarded through a system of public procurement. When private providers are reimbursed at a flat rate for a given number of children, this can result in lower wages and fewer staff. Reduced labour costs contribute to lower running costs and so higher profits.

Informal care continues to be the dominant form of both child care and social care. Increased government funding and the expansion of child care providers are influencing different types of care worker. Child care is more widely recognised at both national and European levels as a priority than social care for older people.

4. What is the extent of the cross-border mobility of workers delivering social care services within Europe?

Between 1995 and 2001, 2 million jobs were created in health and social care services, 18% of the total jobs created (European Foundation, 2006). Cancedda (2001) identified several barriers to job creation in the care sector. These were economic, administrative, and cultural obstacles, as well as the extent of informal care, and lack of government subsidies to create jobs. In addition, low pay, the poor image of care work and limited training opportunities have contributed to dampening the latent demand for care services. In many countries, the care sector faces a shortage of labour and is unsuccessful in attracting younger workers. There is also a high turnover of workers, due to poor career prospects and working conditions. The predominance of older workers in the social care sector also has implications for maintaining a labour force.

Increasingly EU and national migration policies are having a major influence on the social care labour market. Although the EU internal market legislation promotes the freedom of movement for workers, in July 2005, a Directive was published to "*boost mobility*" and guarantee equality of treatment. However other measures such as the freedom to establish businesses, which authorises the transfer of labour, and a draft directive on freedom to establish businesses, which involves liberalisation of temporary sectors, are expected to have a negative impact on workers. The deregistration of unemployment benefits and transfer to social assistance, in some countries, will also impact negatively on migrant and temporary workers (*Centre Public d'Action Social de Bruxelles*, 2006). This section will outline the position of migrant workers in the social care labour market by examining the migration trends within a selected number of countries in Europe.

There have been significant increases in inflows of foreign workers, into many countries of the European Union, over the past decade. In the period 1995-2005, inflows of foreign workers increased in almost all countries (Appendix A). Although almost all countries have experienced annual inflows of foreign workers, their contribution to the overall labour force varies (Appendix B). In countries of Eastern and Central Europe, for example, Hungary, the Slovak Republic and Czech Republic, the percentage of foreign workers in the labour force is relatively small, often less than 1%. The countries that have experienced larger increases in the percentage of foreign workers in the labour force are mostly Western European countries, including UK, Germany, Austria, Spain and Portugal. France and the Netherlands both showed a slight decrease in the period 1995-2004.

Table 2 shows the share of foreign-born workers in health and other community services, including social services, and domestic services. In Belgium, Germany, Greece, Netherlands, Norway, Sweden, Switzerland and the UK over 10% of health and community services workers are foreign born. Although the levels for domestic services are lower, 12.2% of Spain's domestic services workforce are foreign born. Although the term 'foreign born' can cover workers who have been resident in a country for many years, these figures give some impression of how health and community services depend on foreign-born workers.

Table 2: The share of foreign born employment in health, social service and domestic services (2003-4)

	Health and other community services	Households
Austria	8.8	(0.4)
Belgium	10.7	0.6
Czech Republic	6.1	
France	9.7	5.8
Germany	10.1	0.7
Greece	12.5	
Luxembourg	6.3	4.2
Netherlands	12.2	
Norway	20.7	
Spain	3.7	12.2
Sweden	18.6	
Switzerland	13.4	1.3
UK	14.5	1.0

Source: Dumont, 2006

As a way of complementing Table 3, Appendix C shows the specific nationalities of the foreign labour force in different national contexts. The countries have been grouped according to different social welfare systems and provide a view of which countries are dependent on foreign-born labour, however the data is not specifically related to employment in the health and social care sector.

Table 3 shows the origin of many foreign-born workers, currently working in health and social care sectors. Several countries have estimated the number of migrant workers who are currently working in social care, although because many do not have legal papers, the numbers are difficult to verify.

Table 3: Foreign resident population by nationality and employment in health/ social work, personal services and private households in the EU

	Health/ social Work	Personal Services	Private Households
EU West	11.2	6.6	.5
EU South	5.5	4.3	4.3
CEEC	8.2	4.1	5.3
Turkey	4.3	4.5	0.4
Africa/Middle East	7.2	3.3	2.6
USA Canada/ Australia	10.4	11.5	
Latin America /Caribbean	5.6	12.7	2.8
Asia	11.3	3.8	1.4
Other	7.7	5.1	2.5
Total	10.16	4.96	1.08

Source: Dumont, 2006

In Austria, older people who are assessed to require nursing care , receive a statutory nursing allowance of up to €1,563 per month, subject to their needs. This is not enough to pay for licensed nurses so there has been an expansion of illegal care workers. There are now about 40,000 illegal care workers in Austria, who are not qualified as care workers. These care

workers often live in the home of the person being cared for and receive an "*allowance*" rather than a wage (European Foundation, 2006).

There have been several proposals to try and legalise these arrangements. In 2006, the Social Democratic Party (then in opposition) and the People's Party agreed to legalise the thousands of illegal workers working in the social care sector. This was considered a way of re-organising the social labour market. Since January 2007, these two parties are now in a coalition government, but have been unable to agree on how to reform the private older social care system (European Foundation, 2007).

In the UK, the Worker Registration Monitoring Report reported that 5% of the workers that have entered the UK under the Worker Registration scheme work in the care sector, between May 2004 and March 2006. 11,150 care workers were registered in this period. Other related care occupations that have registered as set out below.

Table 4: Occupations registered under Workers Registration Scheme, UK

Occupation	Numbers
Childminders and related occupations	775
Nursery nurses	275
Care managers	20
Social workers	225

Source: Accession Monitoring Report 2004-2006 Department of Work and Pensions (DWP); Department of Communities; HM Revenue and Customs, UK

The UK is now actively recruiting social care workers from Romania and Poland, usually in formally managed schemes. A growing number of migrant workers from Greece, Italy and Spain that go to be 'live-in' carers with single older people. In Italy, it was estimated, in 2005, that 86% of home care workers were foreign workers. This had increased from 16.5% in 1991 (Future of Social Care Employment in Europe 2006).

Countries that are experiencing shortages of labour are developing policies that aim to promote labour migration in a controlled way. In 2006, Finland adopted the Migration Policy Programme to promote labour migration. The UK has the Highly Skilled Migrant Programme as well as the Worker Registration Scheme, which applied to new member states joining the EU in 2004. From January 2007, UK employers are expected to fill vacancies with EU migrants. Low skilled migration schemes will be limited to workers from Romania and Bulgaria (UK Home Office, 2006). There have been several bi-lateral agreements which have recruited nurses for the Netherlands and care workers in Germany (Cholewinski, 2003).

The private sector has responded to the movement of migrant workers into social care by setting up employment and recruitment agencies. These charge fees to both the person recruiting and the worker being recruited. In Austria, private agents link people requiring care to illegal care workers. Those requiring care often pay €100/ month fee and workers have to pay 20-30% of their earnings to the agent (European Foundation, 2006). In the UK, Lifecare Consulting Limited, a company that previously worked in pharmaceutical sales in Africa, is now involved in training, immigration consultancy and care employment. It is planning to move into residential and nursing homes in the near future (Life-care, 2007).

The process of cross-border mobility plays an important role in providing care workers in many European countries. Both legal and unregistered migrants work in the social care sector, partly because of the low status of care work and the problems of recruitment. This raises issues of how to meet training needs of care workers. There are several projects throughout Europe, which are trying to deliver training for migrant social care workers (Hansen, Jensen and Moss, 2004; Skills for Care SW, 2007).

5. To what extent is the registration of care work changing the nature of care work?

A demand for higher standards of care, recruitment problems, a need to change the image of care work and responding to cases of poor standards of care are often addressed through a series of measures that aim to strengthen social care as a profession. These often vary from country to country, depending on the history of social care, educational systems, and wider training policies.

Terminology
There are several terms, which characterise the process of professionalisation of social care. A care worker may become accredited to practice through a recognised process of training and practical experience. The process of accreditation aims to guarantee of minimum standard of practice. A series of minimum standards may inform the development of a Code of Conduct, which will set out guidelines for how care professionals should operate. A Code of Conduct is not necessarily legally enforced.

Some countries have established national registers of care workers. In order to become a member of a national register, a care worker will have to fulfil certain conditions, which often includes a specific qualification and some practical experience. This is a similar process to accreditation.

In some countries, national care standards agencies have been set up to manage the process of registration as well as defining minimum standards of practice and training. They may also be involved in the accreditation of training courses.

In other countries, there is no formal process of registration or accreditation, but legislation may set down minimum qualifications, required to work within the care sector. The effectiveness of these arrangements, in maintaining standards of care, depends on how rigorously these systems are monitored and how much scope national agencies have to inspect and enforce minimum standards.

Agreements that set out the minimum number of types of care workers in care settings, are often negotiated between some combination of government agencies, trade unions, professional organisations and employers. In some countries, municipal authorities and trade unions negotiate the minimum numbers of types and level of qualified workers allowed in care settings, at a local level. These vary from locality to locality.

Childcare
In child care, national and European child care strategies are part of a European wide initiative to expand the role of women in the labour force. The provision of adequate child care facilities is now seen as an essential part of expanding the role of women in the labour force. The establishment of minimum standards for child care facilities is now recognised in most countries. Child care is often associated with an element of pedagogy. In some countries, child care workers are called pedagogues. This has raised the expectations of the standards of child care workers.

Table 4: Qualifications required for employment in childcare – Continental Europe

Country	Centre based	Home based	Pre-school
Austria		Need licence and completion of short training	
Belgium	ISCED 3	No requirements	
Germany	Nursery nurses 3 years		Teachers, nurses 3-5 years
France	Puericultrice	Agreement by general council required Compulsory training of 60 hours over 5 years	
Netherlands	Intermediate vocational training ISCED 3	No requirement	Intermediate vocational training ISCED 3

Table 5: Qualifications required for employment in childcare – Nordic region

Country	Centre based	Home based	Pre-school
Finland	3.0 years University training of pre-school teachers or 3.5 year University degree in applied sciences (B.Sc)	3 years University training of teachers 2.5 nurses Municipalities decide on levels of qualifications – most nursery nurse level or equal vocational training (II-level) Daycare – 3 years nursery nurse vocational training (II-level)	3 years university training
Sweden	University education	2-3 years specialised secondary school	University education
Denmark	3.5 years higher vocational training	No mandatory training	3.5 years higher vocational training

Table 6: Qualifications required for employment in childcare – UK/Ireland

Country	Centre based	Home based	Pre-school
United Kingdom	Teachers - 3-4 years graduate training post-18 Nurses - 2 years post 16 specialist training Day care managers required to have level 3	Childminder not required to be qualified but have to complete a pre-registration course approved by local authority	Differently qualified but half of staff required to be appropriately qualified Level 2
Ireland	2 years post-18 training		3 years post-18 degree course

Table 7: Qualifications required for employment in childcare – Mediterranean region

Country	Centre based	Home based	Pre-school
Greece			4 year study at University for kindergarten and pre-school teachers
Italy			Paid same as primary school teachers and have in-service training
Spain	Educator especializado		Teacher/ Maestro certificate needed
Portugal	Early childhood training course BA 4 years	Licensed childminder	*Educadores de infancia* (pre-school teacher BA 4 years)

Table 8: Qualifications required for employment in childcare – Central and Eastern Europe

Country	Centre based	Home based	Pre-school
Estonia			Teacher 1st level higher education or master's level
Latvia			
Lithuania			
Czech Republic			
Slovak Republic			Secondary education with *maturita* certificate or university education
Slovenia			
Hungary	Title of Professional Education	Title of Professional Education	Title of Professional Education

Source for Tables 4-8: Childcare in a changing world, 2006

The issues facing the provision of social care are slightly different to those of child care. Ageing populations in many European countries are creating a growing demand for social care provision. The social care workforce is also ageing in many countries, which will mean that the demand for social care workers will increase as the population ages. There is only a limited awareness that in order to increase the percentage of older people in the labour force, which is an EU Employment Strategy target, there will have to be alternatives to the extensive informal care provided by older people. This will require the establishment of recognised careers in social care, which would improve recruitment and retention of care workers. Some countries are started to increase the levels of training for social care workers.

Table 9 shows the qualifications necessary for employment as care workers for older people by country.

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

	Professional training	Additional measures
Denmark	Nurses - 3 years 11 months education Social workers - 3 years higher education BA Social and health service (SHS) helpers – 1-2.5 years training – further education – after training a SHS worker can apply to train as nurse or social worker	Social and health service helper training introduced in 1991. Recent reforms changed training at basic level to strengthen possibilities to continue education to other professions.

France	National qualification introduced *Diplome d'Etat d'auxilliare de vie sociale* (DEAVS) 500 hours theory 560 hours practical 17 hours personal tutoring	
Germany	Nation-wide Code of Care for the Elderly (2003) - not well enforced	Retraining scheme by Federal Agency of Employment –people trained and retrained as carers of older people.
Greece	Social work training upgraded to degree level Technological education institutions forced to upgrade their training	Initiative to train unemployed graduates in caring professional through short term vocational training
Netherlands	Care work assistant – no training Care work/ social care work helper – vocational training level 2 Care worker - / social care worker - vocational training levels 2 and 3 Social care workers – higher education – 4 year course	
Spain	Home assistants and carers in institutional settings – no qualifications Home help workers and family workers/ older people residential care workers - occupational training (for either unemployed workers or employed carers). Not possible access higher level technician training	
Sweden	Auxiliary nurse, health support worker and nursing assistant / personal assistant - 3 years Upper Secondary School health and caring Family care providers (employed by municipality to provide care – no special education	
UK	New 3 year degree programme in social work through partnerships colleges/ employers Social Care Access Programme (SCAP) for unemployed people funded by Dept. of Work and Pensions (DWP)–	Focus on competency based training rather than upgrading of basic or initial skills National occupational standards database – what expected of job role and benchmarks for qualifications Registration of social workers/ social care managers and in future social care workers
Italy		Family Counter Project – matched migrant workers and families needing care – and provides training

Sources: Employment in Social Care in Europe – European Foundation
Moss et al, 2004

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

Country	Training or accreditation	Additional comments
Czech Republic		Czech Catholic Charity (voluntary & social care provider) runs a course at the Faculty of Humanities in Charles University, Prague

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

Sources: Employment in Social Care in Europe – European Foundation
Moss et al, 2004

In Germany, France and Greece, new qualifications have been introduced as part of a process of professionalizing the social care sector. The Nordic countries, with more extensive systems of social care, have longer established qualifications. Countries in Central and Eastern Europe are introducing new arrangements for accreditation and registration of qualifications. Their experience illustrates the relationship between recognition of qualifications, continual professional training and development and improved quality of services. The development of a European Care Licence is the subject of a Leonardo project, which would help mobility and guarantee standards of care (European Foundation, 2006)

The position of social care registration and accreditation is less advanced than in child care. There is not the same awareness of the need for educational activities within social care. The processes of registration and training will only slowly have an impact on the nature of care work. For existing care workers, it is important to provide opportunities for training. As there is a continuing shortage of care workers in almost all countries, the demand for training is leading to private sector providers becoming involved in training provision.

One of the goals of registration is to make care work more appealing to younger people. A crucial factor in developing training for care workers is whether the training provides opportunities to enter similar professionals, such as nursing or social work. Not all countries

have achieved this synergy between different types of training. This will influence whether younger people are interesting in training to be care workers.

6. What is the impact of volunteers on working conditions and the professionalisation of care work?

Volunteers are part of the non-paid care workforce who, along with carers from the family and non-kin carers, provide informal care. Informal care still plays a central role in care provision.

In considering the impact of volunteers on working conditions and the professionalisation of care work, it is important to understand the role that volunteers play in European societies. There are different national traditions of volunteering and voluntary organisations provide different contributions to local and national care sectors. Similarly, the national profile of volunteers also varies.

A European survey of volunteering commissioned by the European Volunteer Centre (2004), found many national differences in the role of volunteers in society, which are also subject to change. In Germany, the percentage of volunteers involved in social welfare has increased from 4% in 1999 to 5.5% in 2004. In Spain, volunteering is expanding, with 28.7% of volunteers involved in the social services sector, and of these volunteers, 57% are women. 57% of all volunteers are aged 19-29 and those who are higher educated are more likely to volunteer. In Spain the economic value of volunteering is estimated to be equal to the costs of 73,016 jobs (). In contrast, in Austria, people aged 50+ are more likely to be involved in volunteering ((European Volunteering Centre, 2004).

In Austria, volunteers have been seen as way of relieving the work of nurses in homes for older people and providing companionship and mental stimulation for older residents. The project "Help us Help Others" in Vienna, offers volunteers basic training and the opportunity to participate in further training courses, lunch, reimbursement for travel costs with public transport, and personal liability insurance (Brauner, 2006).

In Spain, the third or voluntary sector is often seen as a source of cheap services and labour but it can also offer new initiatives and innovative projects. In Barcelona, the municipality is working with volunteers, to develop initiatives jointly with the health sector. Volunteers can operate as advocates for people in need, providing greater solidarity (Nogue I Sola, 2006).

The potential of volunteers to undercut paid care workers, also has to be considered in the context of the extent of informal care provided by women. EU employment policies are aimed to expand participation in the labour force from 67% in 2005 to 70% in 2010. There are specific targets to expand the participation of women, from 57% in 2005 to 60% in 2010, and older people to 50% by 2010.

Himmelweit (2005) argues that for these employment strategies to be successful, an economic strategy for caring is needed. Women and older people are most likely to have caring responsibilities. Unless there are adequate and flexible means for providing alternative forms of care, there will not be any significant expansion of the labour force. If women and older people start to move back into the labour force, there will be greater demands on formal caring services.

Hammer and Osterle (2001) have developed the concept of "*defamiliarisation*". This highlights the need for social policies to offer freedom of choice either, to provide unpaid work within the family under conditions, which secure an acceptable standard of living, or, not to provide unpaid care work and to secure an acceptable standard of living through labour force participation. The introduction of carer allowances in Sweden and the UK have attempted to start this process of recognising the value of informal care work but the level of allowances is still low.

7. How are collective bargaining arrangements for care workers changing across Europe?

In some countries, there have been new collective bargaining agreements that cover the private and not-for-profit sectors. In November 2003, the Association of Employers for Professions in Health and Social Services and three trade unions signed Austria's first nationwide collective agreement for the private social and health services sector. This covers 35,000 workers in kindergartens, childcare and refugee welfare (European Foundation, 2003).

In late October 2000, the Flemish minister of employment, Renaat Landuyt (Socialist Party), reached an agreement with employers' and employees' organisations on the practical implementation of an agreement for the not-for-profit (also known as "social profit") sector - welfare, healthcare and socio-cultural activities - that was concluded by the parties in March 2000 (European Foundation, 2000).

In Spain, the ECO Platform, established in 2002 to defend social workers and other professionals involved in social work, played a major role in the bargaining of the recent First Agreement of the Social Work Sector in the Community of Madrid. A sectoral assessment found that the specific category of social work activities was undervalued and enjoyed little recognition in society. This led to an agreement negotiated in November 2006. This agreement was signed by the Association of Personal Care Service Companies (*Asociación de Empresas de Servicios de Atención a las Personas*, AESAP), the National Association of Mental Health Nursing (Asociación Nacional de Enfermería de Salud Mental) the Trade Union Confederation of Workers' Commissions (*Confederación Sindical de Comisiones Obreras*) and the General Workers' Confederation (Unión General de Trabajadores UGT).

These examples show that there are new developments in collective bargaining that are drawing the private and not-for-profit into formal agreements. This reflects the growing role that these sectors play in the provision of care services. As the example of the First Sector of the Social Work Sector in the Community in Madrid illustrates, agreements often depend on having strong umbrella organisations that represent, or at least are recognised by, care providers. A barrier to the development of collective bargaining agreements, in the religious non-profit sector, may be the existence of legislation that excludes religious organisations from having to adhere to national employment legislation.

The table that follows show some of the national collective bargaining arrangements that cover social services workers. Countries in Eastern and Central Europe are successfully negotiating higher annual pay increases than in many Western European countries, although they are starting from lower pay levels.

Table 11: Collective bargaining agreements in Europe for the social services sector

Country	Dates	Sector numbers	Pay rise	Hours	Terms and Conditions
Austria	2003	35,000 workers in kindergartens, childcare and refugee welfare			
Czech Republic	2005	Healthcare (133000); **Social services (36000)**; Total (169000)	3%	40 hours/ week	Overtime limit of 8 hours/week. Standby duty at work should not exceed 400 hours a year
Denmark	04/ 2005 - 03/ 2008	Electricity supply (0); Gas (0); Healthcare (0); Local government (0); **Social services** (0);	9.3%	37 hours /week	The overall pay rise for the three years to 31 March 2008 9.3% - this includes a general increase of 5.64% plus 0.26% for other

		Waste management (0); Water (0); Total (633000)			improve-ments and 3.6% negotiated by individual unions
Estonia	01/07/ 2005 until 30/06/ 2006	Healthcare (0); Total (0)	Pay rises for 2005 are 32% for doctors, 36% for nurses and 25% for medical cares. In 2006 the increases are 14% for doctors and 15% for both nurses and medical carers	40 hours/ week	According to the Ministry of Social Affairs, the average hourly wages in the health and social work sector in 2006 were as follows: EEK 82 (€5.24) for doctors, EEK 43 (€2.75) for nurses and EEK 24 (€1.53) for caregivers. However, these statistics include the salaries of dentists, which increases the average wage level considerably. The national minimum wage level in 2007 is EEK 21.50 (€1.37) per hour. 25 January 2007, an agreement was reached to raise minimum wages in the health and social work sector by 25%
Finland	16/02/ 2005- 30/09/ 2007	Electricity supply (1774); Healthcare (121730); Local government (40881); **Social services (95089)**; Water (1193); Total (261512)	4.3% 16.2.05- 30.9.07	38.25	
France	01/01/ 3206	Central government (0); Healthcare (0); Local government (0)	01/01/200 61.8%		
Germany	01/10/ 2005 until 31/12/ 2007	Central government (30000); Electricity supply (35000); Gas (18000); Healthcare (350000); Local government (235000); Regional government (125000); **Social services (100000)**; Waste management (90000); Water (20000)	0%	39 hours/ week	A performance-related pay element will be introduced from January 2007 and negotiated at local level where it can be linked to individual or team performance
Hungary	01/04/ 2006 until 31/03/ 2007	Healthcare (0); Local government (0); Regional government (0); **Social services** (0); Total (500000)	3.00% 01/04/06		3% increase on pay rates and estimated average increase of 4.8% on earnings
Latvia	22/04/ 2004 until 31/12/ 2007	Healthcare (0); **Social services** (0); Total (27039)		40 hours/ week	
Nether-lands	01/01/ 2006 until 30/04/	Childcare **Social services**	2006 0.75% 2007 0.25% 200		

	2007				
Slovakia	until 31/08/ 2005	Healthcare (0); Total (300000)	01/08/04 7%	40 hours/ week	
Sweden	01/04/ 2005 until 30/06/ 2007	Healthcare (10000); Local government (68500); **Social services (17,400)**; Total (95900)	01/01/200 5 2.20%	40 hours/ week	

Source: EPSU Collective bargaining database 2007 (accessed March 2007)
Austria http://www.eurofound.europa.eu/eiro/2003/12/feature/at0312202f.html
Spain http://www.eurofound.europa.eu/eiro/2007/01/articles/es0701059i.html

8. Conclusion

Informal care plays a key role in shaping the formal care sector. Access to informal care influences access to formal care services. National levels of both formal and informal care vary but are influenced by the extent of women's participation in the labour force.

Changes in the nature of funding, in the care sector, are influencing the development of a social care labour market. Individual care allowances are contributing to the development of individualised care, with short term or temporary care workers, often leading to increased '*casualisation*' of care workers.

Migration plays a role in ensuring the provision of care workers in many European countries. Countries will continue to face problems in recruiting care workers because of the low status of the sector and an ageing workforce. In many countries in Europe, at least 10% of their workers in the health and social care sectors are foreign born.

Changes in training and registration aim to raise the profile and status of the sector. Countries are taking different approaches to improving standards of care and often registration, accreditation, and other measures. These will only gradually change the quality of care provided or to what extent young people view the sector as a viable career.

Coherent care labour market policies are needed that recognise the way in which informal caring, migration, training and wider employment policies are interlinked, and which will contribute to improving working conditions in the sector.

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10. Appendices

Appendix A: Inflows of foreign workers into selected EU countries (thousands)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Austria	15.4	16.3	15.2	15.4	18.3	25.4	27.0	24.6	24.1	24.5
Belgium	2.8	2.2	2.5	7.3	8.7	7.5	7.0	6.7	4.6	4.3
Denmark	2.2	2.8	3.1	3.2	3.1	3.6	5.1	4.8	2.3	4.3
Finland	..	..	..	..	..	10.4	14.1	13.3	13.8	14.2
France										
Germany	270.8	262.5	285.4	275.5	304.9	333.8	373.8	374.0	372.2	380.3
Hungary	18.4	14.5	19.7	22.6	29.6	40.2	47.3	49.8	57.4	79.2
Ireland	4.3	3.8	4.5	5.7	6.3	18.0	36.4	40.3	47.6	34.1
Italy	..	..	..	21.6	21.4	58.0	92.4	139.1	..	..
Luxembourg	16.5	18.3	18.6	22.0	24.2	26.5	25.8	22.4	22.6	22.9
Netherlands	..	9.2	11.1	15.2	20.8	27.7	30.2	34.6	38.0	44.1
Norway	..	..	..	..	15.3	15.9	19.0	24.2	25.7	33.0
Poland	10.4	11.9	15.3	16.9	17.1	17.8	17.0	22.8	18.8	12.4
Portugal	2.2	1.5	1.3	2.6	4.2	7.8	133.0	52.7	13.6	6.5
Spain	36.6	36.6	25.9	48.1	49.7	172.6	154.9	101.6	74.6	..
Sweden	..	..	..	..	..	..	..	..	10.2	8.5
Switzerland	27.1	24.5	25.4	26.4	31.5	34.0	41.9	40.1	35.4	40.0
United Kingdom	24.2	26.4	31.7	37.5	42.0	64.6	85.1	88.6	85.8	89.5

Source: OECD Migration statistics. 2005 www.oecd.org

Appendix B: Stocks of foreign born labour force in selected EU countries and as % of labour force

Thousands and percentages of labour force

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Austria	325.2	328.0	326.3	327.1	333.6	345.6	359.9	370.6	388.6	402.7
% of total labour force	9.9	10.0	9.9	137.5	10.0	10.5	11.0	10.9	11.8	11.9
Belgium	363.7	370.9	380.5	394.9	382.7	387.9	392.5	393.9	396.0	427.7
% of total labour force	8.3	8.4	8.6	8.9	8.5	8.6	8.6	8.6	8.5	9.1
Czech Republic	111.9	143.2	130.8	111.2	93.5	103.6	103.7	101.2	105.7	108.0
% of total labour force	2.2	2.8	2.5	2.1	1.8	2.0	2.0	1.9	2.1	2.1
Denmark	83.8	88.0	93.9	98.3	96.3	96.8	100.6	101.9	101.5	106.9
% of total labour force	3.0	3.1	3.3	3.4	3.4	3.4	3.5	3.6	3.6	3.9
Finland	..	..	..	..	..	41.4	45.4	46.3	47.6	48.6
% of total labour force	..	..	..	..	..	1.6	1.7	1.8	1.8	1.9
	1	1	1	1	1	1	1	1	1	1
France	573.3	604.7	569.8	586.7	593.8	577.6	617.6	623.8	515.9	537.6
% of total labour force	6.2	6.3	6.1	6.1	5.8	6.0	6.2	6.2	5.6	5.6
			3	3	3	3	3	3	3	3
Germany	..	..	575.0	501.0	545.0	546.0	616.0	634.0	703.0	701.0
% of total labour force	..	..	8.9	8.7	8.8	8.8	9.1	9.2	9.4	9.1
Greece	..	..	..	..	..	..	413.2	..	..	..
% of total labour force	..	..	..	..	..	..	9.5	..	..	..
Hungary	21.0	18.8	20.4	22.4	28.5	35.0	38.6	42.7	48.7	121.8
% of total labour force	0.5	0.5	0.5	0.6	0.7	0.8	0.9	1.0	1.2	1.4
Ireland	42.1	52.4	51.7	53.7	57.5	63.9	84.2	101.7	..	..
% of total labour force	2.9	3.5	3.4	3.3	3.4	3.7	4.7	5.5	..	..
									1	
Italy	332.2	580.6	539.6	614.6	747.6	850.7	800.7	840.8	479.4	..
% of total employment	1.7	2.6	2.4	2.7	3.6	4.0	3.7	3.8	6.0	..
Luxembourg	111.8	117.8	124.8	134.6	145.7	152.7	169.3	175.1	180.4	187.5
% of total employment	52.4	53.8	55.1	57.7	57.3	57.3	61.2	61.3	65.5	62.0
Netherlands	282.1	280.5	275.2	269.5	267.5	300.1	302.6	295.9	317.2	299.4
% of total labour force	4.0	3.9	3.8	3.6	3.5	3.9	3.8	3.7	3.9	3.8
Norway	52.6	54.8	59.9	66.9	104.6	111.2	133.7	138.4	140.6	149.3
% of total employment	2.5	2.6	2.8	3.0	4.7	4.9	5.7	5.8	6.3	6.6
Portugal	84.3	86.8	87.9	88.6	91.6	99.8	233.6	285.7	298.0	303.0
% of total labour force	1.8	1.8	1.8	1.8	1.8	2.0	4.4	5.3	5.5	5.5
Slovak Republic	3.9	4.8	5.5	5.9	4.5	4.7	4.4	4.7	5.0	2.8
% of total labour force	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1
Spain	139.0	166.5	178.7	197.1	199.8	454.6	607.1	831.7	982.4	1076.7
% of total labour force	0.8	1.0	1.1	1.2	1.1	2.5	3.4	4.5	5.2	6.3
Sweden	220	218	220	219	222	222	227	218	221	216
% of total labour force	5.1	5.1	5.2	5.1	5.1	5.0	5.1	4.9	4.9	4.9
Switzerland	728.7	709.1	692.8	691.1	701.2	717.3	738.8	829.6	814.3	817.3
% of total labour force	18.6	17.9	17.5	17.4	17.6	17.8	18.1	..	20.5	20.6
United Kingdom	862	865	949	1 039	1 005	1 107	1 229	1 251	1 322	1 445
% of total employment	3.4	3.3	3.6	3.9	3.7	4.0	4.4	4.6	4.8	5.2

Source: OECD migration statistics www.oecd.org

Appendix C: Stock of foreign labour by nationality (thousands)

a) Nordic region

000s	Finland	Denmark	Sweden	Norway
Finland	-	1.0	49.0	4.0
Denmark		-	17.0	10.4
Sweden	3.7	5.7	-	15.3
Norway		6.9	17.0	-
Russian Fed	11.5			
Estonia	8.0			
Germany	1.4	7.0		
Turkey	1.3	11.8	6.0	3.8
UK	1.6	7.6		6.2
Pakistan		2.4		6.0
Poland			5.0	4.0
Sri Lanka				4.5
Former Yugoslavia	1.6	3.7	8.0	
Iran			4.0	
Somalia	1.2			
Iraq	1.1			
Iceland		3.1		
Other	17.2	57.7	110	82.7
Total	48.6	106.9	216.0	149.3

b) Continental Europe

	France	Belgium	Netherlands	Germany	Austria
Turkey	71.7	21.1	42.4	937.0	54.6
Italy	57.5	86.3	10.4	389.0	
France		77.7	8.7	64.0	
Germany		10.9	37.0	-	39.9
Morocco, Tunisia, Algeria	456.9	39.9	29.2		
Belgium		-	20.7		
Netherlands		38.0	-	83.0	
Portugal	349.9	14.2		76.0	
Bosnia/FYoG/Croatia				475	168.4
Greece				189.0	
Hungary					37.6
Poland	21.6	7.7		144.0	12.0
Romania					11.0
Czech Republic/ Slovak Rep					12.4
Slovenia					4.3
Philippines					3.1
Spain	47.7	21.7	8.6	70.0	
UK			25.8	73.0	
DRC		8.7			
Austria				124.0	-
Other	532.3	(total326.2)	116.6	1,079	10.0
Total	1,537.6		299.4	3,703.0	362.3

c) UK/ Ireland

	United Kingdom	Ireland
United States	68.0	7.0
Australia	63.0	
India	97.0	
Italy	67.0	2.8
Ireland	172.0	-
United Kingdom	-	62.0
France	51.0	5.9
Portugal	50.0	77.7
Other	877	72.8
Total	1,445	150.5

d) Greece and Italy

	Greece	Italy
Albania	246.7	145.6
Bulgaria	27.5	
Romania	17.3	194.4
Morocco		164.8
China		79.0
Philippines		60.7
Other	121.7	835.9
Total	413.2	1,479.4

OECD Migration statistics 2005 www.oecd.org