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Care Services for Older People in Europe - Challenges for Labour

Executive Summary & Recommendations

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Executive Summary and Recommendations

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

Care work

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

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

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

Netherlands) (Lyon & Glucksmann, 2008). The key question is whether care is provided in a regulated framework or not. This paper focuses on the delivery of formal (regulated) care, whilst recognising that there is a relationship between informal and formal care. A decline in informal care leads to an increased demand for formal care and this process is taking place in several European countries. Care work is rarely a separate field of policy but is the responsibility of different parts of government.

EU level

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

elaborated a Common Quality Framework for social services of general interest (September 2010) aiming to address different aspects related to their quality. It proposes a European concept of quality that is flexible, compatible with and complementary to existing national quality systems in the sector, and can be applied to services that are organised at the local or regional level. A draft ILO Convention on domestic work is being prepared but unlikely to become part of national legislation for several years.

Life expectancy

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

Expenditure

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

Types of care

There are broadly three types of long term care. Institutional care may cover nursing homes and care homes run by public, private or not for profit providers. Home care, an expanding type of long term care, covers both nursing care and basic living services delivered at home. Informal or no specific formal care covers care that is

provided by family or friends or a situation where an older person does not receive any care from formal providers of care.

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

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

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

Funding for care services

Countries grouped under the heading of Continental Europe use mainly social insurance and some taxation to pay for social care. Long term care systems within the Nordic regions are all tax based but there are some variations between countries. All share an assumption that the state has a responsibility for looking after children, people with disabilities and older people.

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

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

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

Provision of care services

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

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

Workforce

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

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

labour has led to the use of migrant labour in care services.

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

Trade union organising

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

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

are expected to affect an increasing number of care workers.

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

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

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

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

Training

There have been some significant changes in the provision of training for

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

New ways of working and new services

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

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

Conclusion

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

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

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

1. Personalisation/ home care policies

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

2. Pay

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

3. Qualifications and training

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

4. Quality framework

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

5. Promoting care work

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

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

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