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Abstract

Rapid population ageing has dramatically increased the social and economic cost of elderly care. Demand for care labour is increasing rapidly, and all countries are experiencing problems in recruiting enough workers to meet demand. In some countries, the shortage of care workers has been met by a large inflow of immigrant, mostly female, workers. The paper's aim is twofold. To argue that the way in which care is provided and financed may entail large differences in the creation of a formal care market. Provision in kind and 'tied' monetary transfers - that is, cash benefits that are somehow regulated - may prevent the formation of a large informal care market. National employment models in turn shape the features of the care labour market: in fact, they affect the quantity and the quality of the care labour supply, the size of the care labour shortage, and the degree of dependence on migrant carers. We show how these two factors combine to shape the characteristics of care regimes and their long term sustainability.

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1. Introduction

Rapid population ageing has dramatically increased the social and economic cost of elderly care. While increasing awareness of the need for public concern is bringing about some form of public involvement even in the most familistic welfare states, projections of future spending on long term care portend a severe problem of sustainability cutting across the various care regimes. Solutions have been looked for in two directions: reduction of entitlements - targeting services more closely on the population in greatest need - and reduction of the costs of care. 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. Demand for care labour, however, is increasing rapidly, and all countries are experiencing problems in recruiting enough workers to meet demand. In some countries, the shortage of care workers has been met by a large inflow of immigrant, mostly female, workers. The paper's aim is twofold. To argue that the way in which care is provided and financed may entail large differences in the creation of a formal care market. Provision in kind and 'tied' monetary transfers - that is, cash benefits that are somehow regulated - may prevent the formation of a large informal care market. Moreover, we argue that national employment models¹ in turn shape the features of the care labour market: in fact, they affect the quantity and the quality of the care labour supply, the size of the care labour shortage, and the degree of dependence on migrant carers. The last section shows how these two factors combine to shape the characteristics of care regimes and their long term sustainability.

2. Care regimes and the creation of a care market

The cost of care in terms of provision of goods and services is ultimately borne by society: entitlement to care determines the amount of resources that each society is willing to bestow on dependent elderly; obligation to care regulates how the cost is shared. Each country/society defines the minimum rights to care, and the minimum obligations of family/society, doing so either explicitly through regulation, or implicitly by defining the scope of policy provision. In Southern Europe, families are still legally bound to take care of elderly people; in continental Europe, family responsibilities are regulated implicitly; in the UK and Scandinavian countries, there is no family obligation specified by law and there is a more explicit individual entitlement to a minimum level of service.

Assessing the total cost of long term care for the elderly is not an easy task. Taxation, social and private contributions, and private funds are the sources of financing; and their proportions define the society's consensus on the care regime. In most countries, private households share the burden of care by making substantial co-payments for care provided under public programmes. On the other hand, various channels of income support for elderly persons or their family carers supplement private expenditure: elderly care insurance payments, dependency and care allowances, retirement pensions. In some countries, these last still represent the most important monetary transfer to elderly persons and the main resource with which they pay for care. Increasingly, the carer is also supported by various forms of non monetary benefits, such as tax relief, social security contributions, rights to work leave. The fading of boundaries between health and care adds complexity. In most countries, the health care system provides universal coverage, which is financed primarily by the general budget, although co-payments may be required for most services. The distribution of functions between residential homes, nursing homes and hospitals has varied not only among countries but also among municipalities, possibly giving rise to different assessment criteria for similar services (Oecd 2005, p. 39). Thus home nursing care services may be partly or

¹ See Bosch, G., Rubery, J., and Lehndorff, S. (2007) for a review of European employment models.

fully financed by the health care system, while social services such as home help and nursing home care are means-tested or not covered at all. We thus observe an increasing complexity and complementarity of flows, which makes it difficult to estimate the net cost borne by the family in the various regimes.

Obligation to care and source of funding define different care regimes. Three broad classifications have been devised (European Commission 1999). In the Beveridge-oriented systems, 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, universal insurance schemes, unrelated to income or means, are intended to prevent deterioration towards social assistance. In the Mediterranean and Central-Eastern European countries, families are still the main source of support. Table 1 classifies countries according to entitlement to care and source of funding in effect at the turn of the century.² 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 to change the location of some countries in the cells of Table 1. Thus, as the Mediterranean countries seek to develop more coherent plans for the financing of care (see the “Lei de dependencia” in Spain, the creation of a “National fund for dependency” in Italy, and the Home Help programme initiated by the Greek government with Community funding), they move closer to the two other systems.³

² Any classification implies a certain degree of over-simplification: in the case of France, for instance, social contributions represent less than half the resources used to finance long term care, with local or national taxes making up the remaining part (Lima 2006).

³ Italy and Spain seem to move towards a system funded through taxation: in Italy the financial law 2008 allocated 400 millions euros (over 3 years) for the dependency fund. In Greece, in the last few years the range of services has been expanded and supplemented with open care (the Centres for the Open Protection of the Elderly, known as KAPI) and home care services (the project “Assistance at home” for elderly living alone). The general goal is to get away from the “clinical” model and adopt the “social” model (Karamessini and Moukanou 2006).

Table 1. Elderly care regimes in the EU, end 1990s

| Country groups | Northern Europe Beveridge-oriented | Continental Europe Bismarck-oriented | Mediterranean Countries | Newly accessing 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: European Commission (1999); National Reports.

2.1 The organisation of the care sector

Different combinations of three actors - the state, the family, and the market - give rise to important differences among countries as to how their care sectors are organised. These differences affect the amount of care that each actor is called upon to provide, as well as the organisation of care provision and the characteristics of the care labour market.

There is still considerable cross-country variation in the role played by formal/public care, with the Mediterranean countries - where the bulk of care is still provided by the family - and the Scandinavian countries - with a greater reliance on public provision - at the two extremes. Yet the majority of care is still provided informally: over 80% of total hours of care are furnished by the family. The bulk of informal care is provided by women, with a peak of care-giving in the 45-65 age bracket. As this same group has been targeted by the Lisbon strategy to achieve greater labour market participation, there may be a problem of reconciling two potentially conflicting targets. Men's share is higher where elderly people are living as couples. Spouses in fact play a disproportionate role in elderly care. Since an increasing number of people are living alone, this will increase the demand for formal care. Women aged 75 and above are at the highest risk of living alone. Thus, women are at the forefront in both the supply and the demand for care.

Countries also differ in the relative weights assumed by institutional and home care services. Table 2 provides a comparison across countries and over time. It should be noted that the data in the table may reflect different classification criteria (in the case of Austria and Germany, for instance, only nursing homes are counted under residential care). Moreover, they do not indicate the quality of services: for instance, the number of hours of home care services received by elderly persons, or the quality of residential care. However, the table clearly shows that market services (both public and private) are least developed in the Mediterranean countries.

Table 2. Percentage of elderly people (65+) in residential and home care

| Country | Residential | | | Recipients of home care services | | |
|---------|-------------|------|-----|----------------------------------|------|------|
| | % mid-1990s | Year | % | % mid-1990s | year | % |
| Sweden | 5.4 | 2005 | 6.0 | 13.0 | 2005 | 9.0 |
| UK | 5.1 | 2000 | 5.1 | 13.0 | 2002 | 20.3 |
| France | 3.0 | 2002 | 7.9 | 7.0 | 1998 | 7.9 |
| Austria | 4.7 | 2000 | 3.6 | 3.0 | 2000 | 14.8 |
| Germany | 5.0 | 2003 | 3.9 | 3.0 | 2003 | 7.1 |
| Spain | 2.8 | 2004 | 3.7 | 1.0 | 2004 | 3.1 |
| Italy | 2.0 | 2000 | 2.1 | 1.3 | 1999 | 3.0 |
| Greece | 0.5 | 2001 | 0.6 | ... | 2005 | 4.1 |

Sources: For the 1990s, OECD (1996). For later data, OECD (2005, p. 41), and National Reports.

As noted, projections of future spending on long term care portend a severe problem of sustainability, and this has prompted a search for solutions. A reduction of entitlements, increased charges to recipients and cutbacks in care costs, combined in various proportions, represent a common recipe (OECD 2005, p. 86). Cost reduction has taken mainly two forms: a search for cost effectiveness, for instance by resorting to technology to save labour or to achieve the closer integration/coordination of social and health services, and greater reliance on cheaper forms of provision. In the latter case, the total amount of care labour may even increase, with savings gained from contracting the care out to firms, or to family members which do not ‘cost’ them, or cost them at a lower value.

Two common trends are changing the organisation of the care sector: a shift to domiciliary care away from institutionalisation, and a move away from the in-kind provision of services towards private procurement - either through direct contracting-out to private (for-profit and non-profit) organisations, or through greater reliance on cash benefits. We may thus witness convergence to a model consisting of public responsibility, private (market) provision, and greater family involvement.

The shift to home care. The shift in favour of home care (both formal and informal)⁴ is intended to delay institutionalisation and to match the preferences of the elderly person. A declining trend in residential care is more evident in countries where it is most developed: e.g. in the Scandinavian countries and in France, where home care is developing faster than residential care. The trend is still on the rise in those countries – namely the Mediterranean countries, and especially Spain – which lag behind in residential care, although the upward trend may be thwarted by other, cheaper solutions, such as home care services provided by immigrants.

⁴ The traditional distinction between informal care provided by the family (spouse, daughter/son, other relative, friend) and formal care provided by an employee – either public or private – on a regular basis is being blurred by the increasing use of income support or insurance allowances to pay for family carers or to hire ‘informal’ carers in the market – such as paid immigrant carers. The term ‘formal care’ is used here to refer to regular employment, and ‘informal care’ to that provided by family or irregular workers.

With family care already at its limits, the shift of care to the community requires greater public support for the dependent person and the family carers. Public policy has indeed shifted a larger share of resources to home care services in order to maintain disabled older people in their homes where possible, rather than in care institutions. This has been done in a number of ways: from providing more support services - such as respite and counselling, and larger supply from home-care providers in the community - to investing in new forms of residential care and adoption of new technology and innovation to postpone institutionalisation. However, it is financial incentives – monetary transfers such as care allowances or vouchers - that have been most widely used to encourage family members to furnish care. Financial payments may be supplemented by other measures supporting the family carer, such as entitlement to pension contributions, social and accident insurance, tax exemption, training courses, rights to work leave, and reduction of working time. The situation is in continuous change; but despite still marked cross-country differences, there is a clear common trend towards providing some sort of carer support (table 3).⁵ As a result, in half of the countries for which data are available, home care now accounts for more than 30% of total public long term care expenditure (OECD 2005, figure 1.4).

Table 3. Public support for the informal carer

| Measures | Countries |
|--|---|
| <ul style="list-style-type: none"> • Monetary transfers (Financial aid) | <ul style="list-style-type: none"> • Austria, Denmark, Finland, France, Germany, Ireland, Italy, Portugal, Spain, Sweden, Norway, Hungary, Switzerland, Poland |
| <ul style="list-style-type: none"> • Tax relief | <ul style="list-style-type: none"> • Spain, France; Germany, Greece |
| <ul style="list-style-type: none"> • Qualifying for social contributions | <ul style="list-style-type: none"> • Austria, Denmark, Finland, Luxembourg, Germany, Switzerland |
| <ul style="list-style-type: none"> • Respite care | <ul style="list-style-type: none"> • Finland, Germany, Italy, Luxembourg, Sweden, Switzerland |
| <ul style="list-style-type: none"> • Training for the caregiver (or the privately hired minder) | <ul style="list-style-type: none"> • Belgium, Germany, Italy |
| <ul style="list-style-type: none"> • Compulsory insurance | <ul style="list-style-type: none"> • Germany |
| <ul style="list-style-type: none"> • Rights to work leave | <ul style="list-style-type: none"> • Austria, Denmark, Finland, France, Germany, Netherlands, Spain, Sweden |

Source: OECD (2005); European Commission (2007); National Reports.

⁵ The UK is still unique in giving legal recognition and associated rights and services to family carers under the Carers' Equal Opportunities Act 2004.

The shift to private provision. The second trend is a shift to private provision occurring both in the form of the contracting-out of services previously provided by local authorities and in the form of a shift from in-kind services to in-cash allowances. In the latter case, families can then spend their allowances to buy services from the market. The UK has gone furthest in the outsourcing process, in response to an explicit shift in government policy in favour of ‘privatisation’.⁶ At the other extreme, in Sweden subcontracting arrangements have increased, but they are still a minority source of provision: home care services remain dominated by the public sector in terms of both financing and provision (Ahmed and Anxo 2006). In other countries, subcontracting by municipal authorities has grown rapidly: in Italy non-profit organisations (mostly social cooperatives) now provide the bulk of home care services (about 69% of total social workers, according to a recent estimate: Da Roit and Sabatinelli 2005). Private organisations can pay lower wages and operate much more flexibly than the public sector (for instance, by providing care in unsocial hours), thus constituting a cheaper source of care services (Simonazzi 2006).

The common trend towards the greater role of services provided by the market has resulted in different divisions of the care market among public, for-profit, and non-profit organisations (table 4).⁷ In Spain and Greece, in the absence of a substantial public policy, private organisations still perform a major (and autonomous) role: mostly religious organisations in Greece (Karamessini and Moukonou 2006), mostly for-profit organisations (93%) in Spain (Miguélez, Lope and Olivares 2006).

Different types of providers coexist: individual workers and small companies active at the local level (France, especially in home care), non-profit organisations (Austria, France, Germany, Sweden) and social cooperatives (Italy, Spain), small private firms along with non-profit organisations run by the church (Greece); large private firms (France for residential homes, Spain); large non-profit organisations (France and the UK). There is a gradual trend towards a concentration of providers: in 2001 in France 20% of private residential homes were being run by 5 companies, while in Spain some large integrated firms – operating throughout the country, offering the entire range of care services, and with the public administration as their main client – have developed in recent years (Miguélez, Lope and Olivares 2006). Private for-profit firms tend to concentrate in residential care, although a trend towards consolidation of the residential and home care segments can be noted in some countries, with large integrated firms offering the entire range of care services (Spain; social cooperatives in Italy). On the other hand, tight budget constraints (UK) and/or competition from cheap alternatives (immigrant carers in Italy), together with the shift to home care, are driving private companies active in residential care out of the market (or out of activities more intensive in health tasks, such as nursing homes).

⁶ According to Anxo and Fagan (2005, p. 143) “At a national level, in 1992, nearly all home care service hours were provided by home care employees from the public sector, but by 1998 nearly half were from the ‘independent sector’ (both non-profit and private companies). Most of the subcontracted providers are for-profit companies”.

⁷ This trend has assumed dramatic proportions in East Germany. Before unification, there were huge differences in the structure of supply between the East and West. From 1991 to 2001, the share of public providers in the new Länder decreased from 80% to 15%, while the market share of private providers increased from 0.8% to 21% and that of non-profit providers from 20% to 64%. As a result, in East Germany the providing structures have almost completely aligned with the patterns of West Germany, despite persisting wide differences in economic and social conditions (Kümmerling 2006).

Table 4. Type of firms in the care market (% of total), 2003-06

| | Public | Non-profit | For-profit |
|-------------------------------|--------|------------|------------|
| Germany | | | |
| Home care | 2 | 43 | 55 |
| Nursing homes | 7 | 55 | 37 |
| Austria | | | |
| Home care | 90 | | 10 |
| Residential care | 51 | 27 | 22 |
| France | | | |
| Home care ¹ | 35 | 60 | 5 |
| Residential care ² | 60 | 26 | 14 |
| Italy | | | |
| Home care ³ | n.a. | 69 | n.a. |
| Residential care | 48 | 35 | 17 |
| Spain | | | |
| Residential care | 40 | n.a. | n.a. |
| UK | | | |
| Home care ⁴ | n.a. | n.a. | 72 |
| Residential care | 7 | 17 | 71 |

Notes: ¹ = number of organisations; ² = number of places;
³ = % of social workers; ⁴ = expenditure.

Source: National Reports.

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 shift to monetary transfers and private provision is intended to enhance the role of the market and to promote efficiency by favouring the reorganisation of the care sector into a multiplicity of competing actors. This raises issues concerning the regulatory oversight of care options, control over the quality of care as well as the working conditions of workers in the care labour market. Since the private market for care is still closely dependent on public funding,⁸ even when the

⁸ In the UK, for instance, social care is mainly provided by the independent sector, but mainly financed by the state. In 2004, 60% of domiciliary care providers were reliant on local authorities for more than three-quarters of their business, up from 46% in 2000 (Urwin and Rubery 2007).

state/local authority contracts out its services, it can retain governance and coordination of private provision, thereby ensuring quality standards. However, whilst a drive towards private provision is deemed compatible with a strong public role in guidance and supervision, which sets the standards for skills, working conditions and quality of care, opinions differ as to what should be the right degree of competition in the 'social' market for care. Thus, governance is exerted to very different extents among countries. The market is highly regulated in some countries (as in Austria - where competition is restricted and market shares are allocated by the government - and in Germany). In the UK, the state has governed the contracting-out process by maintaining control over quality. In Italy, the public sector *finances* the spontaneous organisation of the market without 'governing' it (Spano 2006, p. 65). In Italy, again, tight control over public provision goes hand in hand with complete neglect of what happens outside the public sphere: local authorities in some regions try to govern the market for publicly-funded social care via 'tacit' agreements on market shares allocation among various social cooperatives, whilst others are more willing to sustain competition in the social market as a way to ensure quality and cost efficiency. 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. The public authority can exert control by attaching conditions to the granting of allowances. In Spain, for instance, companies authorised to perform elderly care functions must comply with the conditions concerning employment, pay, and the quality of services stipulated by the local municipality (Miguélez, Lope and Olivares 2006). In Italy, attempts to coordinate care workers (mainly immigrants) directly employed by families are currently under way, especially through credentialing, professional or training courses, and organisation into cooperatives. It should be noted, however, that quality standards may conflict with budget constraints, so that attempts to improve working conditions in the sector are severely undermined. This is especially true when local authorities set prices *and* quality standards for private firms.

2.2 *The financing of care*

Care regimes - that is, the ways in which the financing and provision of care are organised in the various systems - differ in their capacities to create a care market, either social or private. In fact, how the care market works depends as much on the system of funding as it does on the way in which funds are disbursed. Systems relying on in-kind provision, contracting-out and 'tied' in-cash allowances (to be used to hire private carers) are the most effective in creating a formal market. Conversely, those systems that rely mostly on in-cash unconditional allowances (monetary transfers) have slowed down the creation of a formal market for care, encouraging instead supply from the informal market consisting of either family carers or carers hired by the family in the market. Analysis of the effects of disbursement on the care market is of utmost importance, given the common trend towards more cash benefits and the Mediterranean countries' recent move to create a national fund for dependency.

Two groups can be distinguished: countries which rely mostly on in-kind provision, either directly or via contracting-out (Sweden, UK) or with a greater reliance on conditional cash allowances paid to hire an external regular carer (as in the French system); countries which rely mostly on unconditional allowances paid to the family carer (e.g. care insurance in Austria and in Germany, and the attendance allowance in Italy).

In the first group of countries, the care regime has favoured the creation of a formal market for care. In Sweden, municipalities are the main providers of care for older people, and public providers cover 95% of services; although, as noted in the previous section, Sweden exhibits the common trend towards the contracting-out of services for older persons (Ahmed and Anxo 2006). In the UK, services are provided by local government and by the private sector on contract to local

governments, with the share of the public sector declining drastically since the 1980s. In France, the policy on care allowances has been distinctive by explicitly linking the provision of services to the elderly (and other family services) with the creation of jobs, the specific intention being to reduce long-term unemployment and to drain the informal market (Dherbey et al. 1996, Jenson and Jacobzone 2000; Lima 2006). Since the beginning of the 1990s, various schemes⁹ have been designed both to address the needs of vulnerable categories and to create jobs. French beneficiaries of the home care allowance must spend it on care (and they must be able to prove they have done so), and they can use the allowance to purchase care from family members (other than spouses or partners) only if the latter are unemployed. In the late 1990s it was estimated that this policy had achieved its primary goal of expanding regular employment and formalizing care arrangements (Jenson and Jacobzone 2000): recipients tended to hire outside caregivers over family members by a margin of two to one.

A feature shared by Germany and Austria is that their care systems are based on mandatory care insurance largely paid in cash with no strings attached. Long term insurance only provides limited cover (table 5)¹⁰: the allowance is meant, in fact, to act as a strong incentive for ‘self-support’ (Hermann 2006). The Austrian care allowance (Pflegegeld) is unconditional and not means tested; it can only be paid in cash (either to the dependent person or to the family carer); and it can be used either to pay the family carer or to hire a service in the market, or to pay for residential care. The amount of the benefit is linked to the degree of disability: more than half of all recipients (56.7%) are at level one or two of the care allowance scheme, that is, up to 273.40 euros in 2006, equal to 75 hours per month (Hermann 2006). There are additional benefits, provided by the provincial governments through social assistance, which are means tested and aimed at people in financial need.

Table 5. Cash transfers: maximum allowance*

| Austria (2006) | Germany ^o (2006) | Italy [^] (2006) | France (2006) |
|-------------------|--------------------------------|------------------------------|------------------|
| 1562 | 665 | 450 | 1169 |

* Highest level of disability

^oMaximum value for benefits in-kind: 1432 euros

[^]Italy: Attendance allowance only.

Source: National Reports

The German care insurance (Pflegeversicherung) can be paid either in kind or in cash, or as a combination of both. The cash payment is significantly lower than the direct service benefit: for a given degree of disability, the in-kind transfer is about twice the cash transfer (table 5). In-kind transfers can be used only to purchase legally defined health services. The service provider must be a professional carer and must have an agreement with the LTC insurer. The latter ensures that

⁹ The Prestation spécifique dépendance (PSD), the *Allocation personnalisée d'autonomie* (APA) and, since January 2006 the Chèque Emploi Service Universel (employment voucher).

¹⁰ It is estimated that in 2001 additional funds in the Austrian system totalled between 1.6 and 3 billion Euros, as against 1.69 billion Euros, or 0.8% of GDP, for the federal allowance (Hermann 2006). In France a low income elderly person (earning 7756 euros) at the highest level of dependence must spend 67% of his/her income to make up the total cost of care (Lima 2006).

providers fulfil certain standards, such as a specific share of care professionals among their employees (Arntz, Michaelis and Spermann 2006). Anyone receiving cash benefits must request care advice from a professional care service, but the benefit can be used for any type of purchase, including gratuities for relatives (Arntz et al. 2007). Although applications for cash benefits in Germany seem to be slightly decreasing, in 2002 more than half of recipients opted for the in-cash payment (table 6). Similarly, 81% of Austrian recipients have used the allowance to recompense family care (compare these numbers with France, where recipients tend to hire outside – regular – caregivers by a margin of two to one).

Table 6. Use of Insurance allowance: Germany and Austria, 2002

| | Germany | Austria |
|-------------------------|------------------------|------------------------|
| | % of recipients | % of recipients |
| Cash allowance | 50.4 | 80 |
| In kind/mixed | 19.1 | 5 |
| Residential care | 30.5 | 15 |

Source: Kümmerling (2006); Hermann (2006).

The combination of unconditional money transfers favouring informal care with a closely regulated system of qualifications and professional degrees has produced a dualistic market. This outcome is more pronounced in Austria, where immigrants from Eastern Europe make up large part of the market (section 4 below).

In the Mediterranean countries, the limited public involvement in care financing explains the failure of those countries to develop a formal care market for older people and the dominance of individual suppliers. In Italy, public funds have been used largely to recompense the family carer. Two types of allowances – tied and untied – coexist. The *attendance allowance* for dependent persons with severe disabilities is not ‘tied’: it is not means tested, nor is it conditional on the family structure of the person in need (it amounted to €450 per month in 2006). The *care allowance* is means tested and is granted by local authorities to elderly people at risk of institutionalisation. It is usually smaller and much less widespread than the attendance allowance, but the local authorities can more easily subject its payment to compliance with rules. As well as these allowances, every elderly person can rely on at least a minimum pension amounting to approximately 450 euros. Although payment of the care allowance has been made increasingly conditional on the hiring of regular immigrant carers in order to reduce the size of the informal market, the prevalence of unconditional monetary transfers, in an unregulated labour market with a large informal economy, has led to the development of a large supply of irregular, often undocumented, immigrant carers.

At the cost of simplification, we may argue that when comparing care regimes, much of the difference among them derives from the way in which financing is disbursed. Their insurance schemes notwithstanding, in fact, Austria and Germany can still be described as having a “publicly facilitated, private care model” (Bettio and Plantenga 2004). Contrary to the Beveridge-oriented care regimes, care is provided mostly in private or informal manner; but in contrast to the Mediterranean countries, costs are “partly compensated by collective arrangements” (Hermann 2006). To conclude, the decision to emphasize cash benefits instead of agency-based services – which has been explained by the need to promote greater consumer choice and control over service options (OECD 2005) – may affect much more than consumer choice alone. By transforming dependent elderly people and their families from service users into service buyers and employers of

care workers, the increased use of care allowances and vouchers affects family care-giving responsibilities and the structure of the care market.

3. National employment models and the supply of care workers

3.1 The care labour market

National employment models shape the features of the care labour market: in fact, they affect the quantity and the quality of the care labour supply, the size of the care labour shortage, and the degree of dependence on migrant carers.

Table 7. Total employment in the elder care sector

| | Germany (2003) | England ¹ (2003/4) | Sweden 2004 | Austria ² 2002 | France | Italy 2004 | Greece 2001 | Spain 2003 |
|---|-------------------|----------------------------------|----------------|------------------------------|----------------------|---------------|---------------------|---------------------|
| Home/Domiciliary care | 200,897 | (163,000) | | 3,400 | 800,000 ³ | 30,000 | | |
| Nursing homes/ Residential care Homes | 510,857 | (462,000) | | 16,963 | 134,000 ² | 125,000 | | |
| irregular workers (estimates) | | | | (40000) | | (500,000) | | (50000) |
| Total | 711,754 | 625,000 | 239,500 | 20,636 | 934,000 | 655,000 | 21,325 ⁴ | 150000 ⁵ |
| Population >65 per employee ⁶ | 20.9 | 12.5 | 6.4 | 61.1 (20.8) | 10.7 | 88.9 (17) | 92.7 | 47.7 (35.8) |

Notes: ¹According to Wanless (2006, p. 122), total employment in services for older people in 2003-04 in England alone was 680,000. For the UK as a whole the figures for the two main care roles are 111,677 for social workers and 640,686 care assistants and home carers (Source: ONS Annual Population Survey 2006, in Experian, 2007, figure 1). The figure for the UK is 2.6.

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

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

⁴Total employment in the social care sector.

⁵25,000 of them in Social Services Centres.

⁶The ratio including estimated irregular carers in parentheses.

Source: Employment in the elderly care sector: National Reports; Population over 65 years of age (2004): Eurostat, *Population and Social Conditions*, 2007.

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. Moreover, different labour markets co-exist within the long-term care sector: skilled workers, such as registered nurses; unlicensed low-skilled assistants and other workers providing personal care; domestic service workers providing home help with domestic chores. Because of the credentialing processes involved, more data are available on licensed workers. In general, however, the boundaries among different qualifications tend to be blurred because unskilled workers often have to perform care tasks as well, such as personal cleaning and (elementary) nursing. The contiguity of long-term care with health and social services means that flows between these sectors are quite common. Because the markets, the credentialing, and the data gathering are not distinct, data usually relate to broad categories of workers (Redfoot and Houser 2005). For these reasons,

estimates of total employment (table 7) should be treated with caution. 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.

Pay and working conditions. 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 and private providers; fragmentation of unions among skills and tasks, the decentralisation and fragmentation of bargaining, encouraged by the fragmentation of employers (public, private subcontractor, for-profit, non-profit): these are features common to all countries.

There is a wide disparity in working conditions across employers and types of care. Pay and conditions are usually worse for staff employed by private contractors compared to in-house staff directly employed by public institutions, and for workers in home care compared to 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-pay, 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, so that it may have increased exits from care to other minimum wage paying sectors (such as supermarkets), which have less demanding working conditions. A similar trend can be observed in Italy: after regularisation, immigrant workers seek to move into public services, or out of care into other sectors (such as hotels). Atypical contracts are common, but high turnover and vacancies seem to be 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).

Working time arrangements vary widely across countries and employers, so that an increase in demand for care during 'unsocial' hours is met in different ways: part time, shifts, around the clock co-residing minders. In general, part time in care reflects the features of the national employment model, being generally higher in countries where it is widespread. On the other hand, where opportunities for part-time in other sectors of the economy are scarce, as in Italy's high-employment Northern regions, elderly care provides a way out for young mothers in need of part-time jobs so that they can reconcile work and family care. Many care workers put in uncompensated time (for example, in care planning or client-to-client travel), which decreases their effective earnings per hour.

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

Scandinavian welfare regimes are associated with high levels of services, large workforces and relatively good employment conditions. Sweden's system of long-term care services is designed to

support women in the workplace and to professionalize care-giving to older people needing help. Compared to other countries, Sweden requires the highest levels of education among caregivers and pays the highest wages. Anxo and Fagan (2005, p. 140) observe that “The qualifications levels required for entry to home care work have generally been rising in Nordic countries, from a base that is already high compared to the situation in some other countries such as the UK. Thus in Finland and Sweden, three years of training in upper secondary school is now a typical entry requirement”. According to some estimates (Alaby 2005), ten percent of long-term care workers have university degrees in health and social work, and the other 90 percent are nurse assistants and home-helpers; approximately 60 percent 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, and they have required 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 (Urwin and Rubery 2006; Escobedo et al. 2002).

In France, the development of long term care services has reflected an employment policy intended to increase labour force participation among low-skilled persons (Korzcyk 2004). This policy has encouraged private contracts,¹¹ with negative effects on pay and work and care quality. Pensioners employing home helps are subject to all the requirements applicable to employers, but they benefit from an abatement of payroll taxes on wages paid to these workers. 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 it is required when application is made for rebates on taxes and social contributions. Private contracts tend to pay less than formal jobs with private or government agencies,¹² and they do not offer a career ladder. Lower wages give limited incentives to employees to seek training that might improve their earnings, career mobility, and the quality of care that they provide. Consequently, whilst 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 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). As a consequence of the policy, the care workforce in France has been split into two broad groups. One group of workers has the formal training necessary to pursue a career; the other group is essentially unskilled, with few prospects of upward mobility (Christopherson 1997). The evolution of training in the French home help sector has reflected the tension between the development of home help as a service with increasingly complex professional demands and as an employment programme. If a programme is designed to meet the needs of the long-term unemployed (or those never employed), the result may be the creation of an employment sector reserved for those with no other options. Such a programme may produce jobs, but these are jobs for an underclass which do not offer career tracks and upward mobility¹³. On the other hand, if one focuses on the needs of the service user, the emphasis shifts to

¹¹ Various laws, primarily a 1991 law creating the job category of family employment (*employs familiaux*), have made it easier for individual workers to establish private contracts with clients rather than working through private or government agencies. These arrangements added a substantial number of jobs in the early 1990s (Christopherson 1997).

¹² Private contracts — in which the beneficiary is the employer — tend to pay at or about the minimum wage, while home care jobs through agencies pay as much as 50 percent more. Nevertheless, the minimum wage is judged to provide a decent standard of living for a worker and family, and it is revised whenever the cost-of-living index rises by 2 percentage points (Korzcyk 2004).

¹³ There is a strong competition in the provision of low-level qualifications in home support services. These certificates are quite different from the qualifications required in institutional care, which have a strong health bias, and the entry of

developing appropriate professional skills and the tools with which to measure and promote quality, rather than the programme's impact on employment. Some observers consequently 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 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 are required from workers 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: for skilled and semi-skilled staff. The former consists of graduate nurses, while semi-skilled staff 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 since 2003, elderly care work has been an autonomous profession with standardized vocational training. 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 (Realschule or equivalent) and the duration of the training is three years (full time), followed by a six-month probationary period. Employees with professional training are qualified as nurses or as elderly care workers. Home care is provided by professional staff, with whom the LTC insurance funds stipulate supply contracts. Germany does not have a shortage of adequately trained nurses and elderly care workers. The recent (and still ongoing) structural changes in the hospital sector have led to a severe cutback 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). On the lower skill level, the demand for elderly care workers has been satisfied by so-called retrainees (Umschüler) who have attended training courses partly supported by the Agency for Labour. Yet, 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 is rapidly increasing (the proportion sextupled between 1996 and 1999). In recent years, a parallel market for (often illegal and mainly East European female) health care workers seems to have emerged. The combination of qualified and unqualified workers, and irregular workers, points up 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

social sector diplomas into sectors traditionally attached to the health sector is perceived as a threat by the unions and associations representing nursing auxiliaries (Lima 2006).

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 persons with complex needs to live in the community rather than in specialized institutions.¹⁴ 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 (Korzcyk 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 expel women with lower educations. 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 (Experia 2007).

3.2 The labour shortage and immigrant carers

Demand for care labour is increasing rapidly everywhere and all countries are experiencing problems in recruiting enough workers to meet demand. In some countries the shortage of care worker has been met by a large inflow of immigrant, mostly female, workers. The trend in migrant ‘carers’ reflects the features of overall migration flows. In the EU, the inflow of foreigners has grown rapidly in recent decades, with significant differences among countries. All Mediterranean countries display high levels of immigration, and even higher flows of undocumented immigrants, while Scandinavian countries host a limited number of foreigners. The picture is more mixed for the western continental countries, with Austria and France experiencing a marked growth of inflows, and Germany a declining trend. Finally, in the UK the upward trend is pronounced, and especially so since the EU enlargement to the so-called A8 countries (Ambrosini and Barone 2007) (table 8).

¹⁴The share of qualified workers is generally higher in home care than in residential care, although there is a trend towards a decrease in qualified workers in home care which may reflect shortages of qualified workers (Austria) as well as a finer division of tasks (Italy) aimed at saving on (more expensive) skilled labour.

Table 8. Proportion of non-nationals in total population and in total labour force, 2006

| | Proportion of non-nationals in total population | Proportion of non-nationals in total labour force |
|---------|---|---|
| EU27* | 4.4 | 5.2 |
| Austria | 9.8 | 10.3 |
| France | 4.8 | 5.1 |
| Germany | 8.7 | 9.1 |
| Greece | 5.0 | 6.3 |
| Italy | 5.0 ^o | n.a. |
| Spain | 8.7 | 12.3 |
| Sweden | 3.8 | 4.6 |
| UK | 5.7 | 6.3 |

Notes: * EU27 totals are based on the available country data.

Non-nationals: legal, permanent migrants only.

^o Italy: 2007.

Source: Ambrosini and Barone (2007) on Eurostat data.

For Italy: Istat, *La popolazione straniera residente in Italia al 1 gennaio 2007, Statistiche in breve*, Roma, 2 Ottobre 2007.

Two factors make estimates of the actual flows of immigrants difficult. Different definitions of ‘immigrants’ and ‘foreign born nationals’,¹⁵ as well as differences in the amounts of naturalised foreigners, make cross-country comparisons unreliable. How, in fact, should second or third generation ‘immigrants’ – be they Turks or ‘ethnic Germans’ in Germany, Estonians in Finland, North-Africans in France, or Asians in the UK – be considered? In some countries, such as France, statistics do not distinguish by ethnicity or national origin. Used here is a ‘flow’ definition of immigrant, that is, a person of foreign nationality who has migrated to engage in care work - like most of the nurses actively recruited by the UK or the female carers migrating to Austria on a rotating basis – or who may have ended up in the care sector since this was the only work that he/she could find – as in the case of the first wave of female immigrant carers in the Mediterranean countries.

The second factor has to do with undocumented immigrants. It is difficult to find reliable data on undocumented migrants, and varied and conflicting estimates have been produced. Generally speaking, their presence is higher in those countries with a flourishing informal economy, and they are concentrated in those sectors where the informal economy is most widespread: care and domestic services, hotels and catering, tourism, construction, and agriculture (UWT 2007). The informal economies preceded undocumented migration and acted as a strong pull factor; but subsequently the two processes reinforced one another, thus helping to strengthen the process of immigrant labour casualisation (Bettio, Simonazzi and Villa 2006).

¹⁵ Most countries (with few exceptions, such as the US and France) link citizenship to ethnicity rather than place of birth (OECD 2005a). This affects the comparability of the data. For example, hundreds of thousands of ethnic Germans migrated to Germany after the fall of communism in Eastern Europe. These migrants receive automatic citizenship and are characterised as Germans in the country’s data systems, while ethnic Turks who have lived for generations in Germany often do not have citizenship there and are characterised as “foreign”. The OECD’s 2004 report on migration makes major strides in distinguishing data on “foreign” from data on “foreign-born” to give a more accurate picture of international migration patterns (Redfoot and Houser 2005).

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. These workers co-reside with the elderly person round-the-clock, and stay for a three-month period on a rotating basis.¹⁶ Illegal carers are incomparably cheap¹⁷ and raise serious competition against home service providers (the latter have reported an up to 30% loss of turnover according to Neue Caritas, 2006, quoted in Kümmerling 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 Sweden seem to rely least on immigrant carers. In Sweden, 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.

Foreign long-term care workers fill the gaps in the care chain; they are more likely to take jobs in the less desirable tasks or segments of the market; and they do not compete with professional care workers. In some countries (e.g. Finland), selective immigration policies shield the most sensitive (or the more organised) segments against competition. Differences among countries in their reliance on foreign workers thus derive from the different shortages across the skill spectrum. These in turn are produced by the combined effect of the various long-term care regimes and employment policies (along with their past histories as countries of immigration and their past and current views and policies on immigration). Whilst differences in the organisation and financing of care impact upon the creation of a market for care (as argued in section 2), labour market characteristics and working conditions, as shaped by the national employment model, affect the supply of a 'native' workforce and its professional skills.

4. Care regimes and national employment models

4.1 Formal and informal markets

Interaction between care regimes and the national employment models has produced very different results in terms of the quantity and quality of the "domestic" labour supply, and it may explain the

¹⁶ It has been estimated that there were about 5,000 foreign illegal care givers in Germany in 2002, but they were not distributed uniformly across the country.

¹⁷ It is estimated that illegal carers earn about one tenth of the pay of legal carers, between 600 and 800 Euro plus board and lodging. Similarly, in Austria the pay of an irregular immigrant carer is 7E/h compared with 24E for a trained care worker.

differing capacity to meet increasing demand for care either by using native workers or instead by resorting to immigrant workers to cope with labour shortages. The rest of this section presents a comparative analysis of the various models. The countries examined can be classified in different clusters according to the prevalence of formal or informal care labour markets and to the degree of reliance on immigrant care workers (figure 1). As argued in section 2, care regimes differ in their capacities to create a care market, either social or private. Systems relying on in-kind provision (Sweden), contracting-out (the UK), and ‘tied’ in-cash allowances to be used to hire private carers (France) fall within the formal market grouping. Systems relying mostly on in-cash unconditional allowances or monetary transfers (Austria, Germany and the Mediterranean countries) fall within the informal or mixed categories, depending on the amount and conditionality of public funding.

Figure 1. Care regimes and employment models

| Employment Models | Care Regimes | | | |
|--------------------------|---------------------|-----------------------|----------------|--------------------------------|
| | | Formal Market | Mixed | Informal market |
| | Native | Sweden, France | Germany | |
| | Mixed | UK | Austria | |
| | Immigrant | | | Mediterranean countries |

Source: National reports.

Policies favouring the creation of a care market have obvious effects on the supply of labour, in particular female labour. Those countries that have opted for a high provision of services have the highest female participation rates, and the Mediterranean familistic welfare regimes the lowest¹⁸. This may go some way towards explaining the size of the domestic supply of care workers. However, shortages across the skill spectrum, as well as differences in care quality, are affected also by the specific features of the national employment models. The UK, Sweden and France have favoured the creation of a formal market for care, thus falling within the first column, but they have had different experiences in terms of supply of domestic care labour.

The different characteristics of the employment models in the UK and in Sweden have resulted in widely differentiated shortages of care workers and consequently different amounts of recourse to immigrant labour. Sweden’s supply of care workers consists mainly of native workers. While

¹⁸ In Germany long-term care insurance has led to a massive improvement in the long-term care infrastructure and to the creation of more jobs in the care sector. A total of over 250,000 new jobs have been created since the introduction of the insurance (MISSOC-INFO 2006). The link between care regime and employment creation is acknowledged also in Spain’s debate on dependence. According to the data contained in the White Book, the implementation of the new law on dependence is expected to generate 300,000 jobs.

demand for foreign-born workers may increase, Sweden is determined to prevent the onset of a low-skilled, low-paid market for irregular eldercare workers. The 10-year action plan for long-term care (discussed in 2006) focuses on policies to improve employment and working conditions in order to recruit and sustain a stable long-term care workforce.¹⁹ Conversely, the UK is experiencing severe problems of across-the-board labour shortages. Staffing difficulties are now sufficiently severe to impinge on the implementation of government policies (Urwin and Rubery 2006). Low wages and other poor employment conditions, low levels of educational attainment, a negative public image of social care work, organisational aspects which reduce job satisfaction (e.g. constant change, poor management), and the stress of the work are at the basis of the difficulty faced by the sector in workforce recruitment and retention. The increasing role of the private (mainly for-profit) sector in care services in the UK may be exacerbating these problems. Increasing marketisation of services, combined with budget constraints, has put pressure on costs, encouraging the development of a low paid and casualised workforce. A workforce of this type tends to attract transient, temporary workers and to have a relatively high staff turnover. In France, as argued, the development of long term care services has reflected an employment policy intended to increase labour force participation among low-skilled persons, favour regularisation and drain the informal market. This policy has encouraged the supply of a native work force.

Because of their use of monetary transfers to promote informal/family carers, Germany and Austria combine features of both formal and informal markets. 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 (Kummerling 2006). This explains the allocation of the two countries to different cells: a strongly regulated market for skilled labour, combined with their use of monetary transfers to incentivate informal family carers, justifies their inclusion in a 'mixed' cluster to take account of the coexistence of formal and informal care markets, albeit with differing reliance on foreign minders.

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. These workers compete with the less-qualified ones employed in the private, formal market. Evidence that, in some areas, the commercial sector may be fighting back by formally hiring immigrants (Simonazzi 2006) is indicative of how close the skills of the two groups are.

We can conclude that the low pay and low status that are distinctive features of the sector do not seem to be related to immigrant labour. The opposite is the case: low pay, low status, and immigration are instead affected by the features of the national employment model.

4.2 Future scenarios

The first huge flow of illegal migrants into the Southern European countries occurred in the aftermath of the collapse of Eastern European socialist regimes. This flow was attracted by the size

¹⁹ Basic skill requirements for nurse assistants and home care personnel, and a system of recognition and registration to increase the status of the occupation are among the various measures under discussion. There are also ongoing projects to improve on-the-job training and supervision for care workers and to provide support for their next of kin (Alaby 2005).

of the underground economies of the Mediterranean countries, and it fuelled the development of the 'Mediterranean care model'. Since EU enlargement, most migration from Eastern Europe has become 'internal' (although with large differences among receiving countries' migration policies).²⁰ Legal immigrants can now choose between continuing as 'irregular' workers, as in the Mediterranean countries and Austria, or fuelling the supply of cheap but mainly formal labour (as in the UK). The regularisation of the positions of Eastern European migrants has led to a reshuffling of migratory flows by origin and destination. In Portugal, for instance, the share of immigrants from Eastern Europe – which had been extremely high because of the relatively low cost of obtaining a visa – has diminished in favour of immigrants from Latin America. Eastern European workers are now moving in large numbers to the richer labour markets of the Northern European countries. Their legal status as migrants also influences their migratory projects: they can now move more easily on a short-term basis. This in turn affects the extent of their competition with domestic workers. For migrants with a temporary migratory project, regularisation of their employment position may have little appeal if they can trade it for higher wages.²¹ There is evidence that in Italy, with its maturing 'migrant carer model', the grey market has been prompt to exploit this model's greater social acceptance by 'only just' undercutting regular workers²², thus skimming the market and threatening once again to squeeze lower-middle income families out of paid care, were it not for monetary transfers and social subsidies (Simonazzi 2006). The duration of the migratory project may also affect the career progression and development of immigrants, because neither the employer nor the workers invest in their training.

The flow of cheap, legal carers 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, France²³, possibly Sweden. As for the UK, according to the Annual Population Survey, in 2006 19% of social workers and 16% of care assistants and home carers were born outside the UK.²⁴ Many of them had arrived after 2000 and the trend was rising rapidly: Polish immigrants represent 62% of foreign born workers who registered with the Home Office to work in the UK in "health and medical services" between 2004 and 2006; 64% of Polish-born workers in the social care sector arrived in the UK in 2005 (Experian 2007). A plentiful supply of cheap carers could move the UK down to the bottom-left cell in figure 2.

²⁰ Not only can A8 workers migrate and take up employment in most western European countries without restrictions, but those who had already migrated illegally experienced a 'change of status' similar to an amnesty.

²¹ Moreover, as noted by the Polish Labour Ministry, some immigrant workers register as unemployed back home in order to remain in the state health insurance system and receive other benefits (reported in the International Herald Tribune, July 2007, "Poland faces severe labour shortage as its workers go west").

²² Thus the wage on the black market ranges somewhere between the net and gross regular wage.

²³ Immigrant carers are increasing in numbers also in France, especially in the metropolitan areas.

²⁴ This figure is much higher in London than elsewhere (48 and 68% respectively): better job opportunities and a higher cost of living discourage native workers from taking up a job in elderly care.

Figure 2. Care regimes and employment models

| | Care Regimes | | | |
|-------------------|--------------|----------------|---------|---|
| | | Formal Market | Mixed | Informal market |
| Employment Models | Native | Sweden, France | Germany | |
| | Mixed | UK | Austria | |
| | Immigrant | UK Germany | | Germany Austria Mediterranean countries (?) |
| | | | | |

The second outcome concerns those countries which rely on monetary transfers or which have large informal markets. Here, greater freedom of movement within the enlarged Europe could 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 westward, with greater recourse to immigrant carers but on a formal basis, or eastward to join the Mediterranean countries in the bottom right cluster (fig. 2). In Austria, the options seems to be either an amnesty for those illegal care workers already in the country or the creation of a mandatory care insurance system which (in contrast to the existing care allowance) would fully cover costs and therefore enable care recipients to hire qualified and legally employed staff (Hermann 2006). In Germany, concern about the long-term sustainability of the LTC insurance system has generated an intense debate on the need for reforms. The main proposal is to implement matching transfers (personengebundenenes Pflegebudget), which provide a specific cash benefit equal in value to that of in-kind transfers, to be used for the purchase of appropriate care services (Arntz et al. 2007). By encouraging more people to choose cheaper home care, the matching transfer is intended to replace demand for institutionalisation, thereby reducing long term costs. It differs, however, from a lump-sum transfer in that it may not be used to pay family members or irregular workers. A pilot study to evaluate the effects of this scheme is still under way: if the latter is successful, it may encourage a move away from family care, while opening up the LTC market to a variety of new, regular, care providers.²⁵ To which of the two cells Germany will eventually move thus depends on its degree of success in regulating its informal care market, especially at the lower levels of qualification.

As for the Mediterranean countries, their capacity to move north-west will depend very much on how the newly-established funds are disbursed and on the conditions regulating the formal and informal care markets. The case of Italy provides a good example. As in the other Mediterranean

²⁵ However, the pilot study revealed that, apparently, there was a large fraction of the frail elderly who preferred care arrangements that allowed for informal care within the family to be reimbursed. This aspect discouraged about a quarter of all interested individuals from participating in the experiment (Arntz, Michaelis, and Spermann 2006).

countries with large underground economies, the shortage of care workers in Italy has been filled by undocumented/irregular immigrant workers. Their pay is often extremely low compared with that earned by a regular worker, though much higher than what they could earn in their home countries. A new national contract for domestic workers (in March 2007) fixed the cost to a family of a live-in elderly minder on a regular contract at between 1000 and 1300 euros per month (in addition to board and lodging costs). This compares with average net earnings in industry and services of between 950 – 1250 euros. 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. The Italian case highlights the drawbacks of trying to change working conditions in a sector by decree without considering relative wages and family income levels. It is an open question whether the Mediterranean model as we know it will be able to survive the creation of a formal ‘regular’ market without the support of a national policy able to remedy the problem of dependency.

5. Conclusions

The care sector has two related problems: ensuring that the labour supply of carers keeps pace with increasing demand, and providing quality care in an industry characterized by low wages, poor working conditions and high turnover. Countries with more regulated labour markets have been more successful in securing an adequate supply of native workers to meet demand. The long-term sustainability of care for the elderly is dependent on sound public finances and high labour force participation to finance projected care needs. In these countries, the quality of long term care is usually considered to be fairly high. Conversely, where labour markets are deregulated, or where service buyers have been free to spend their benefits with no restrictions, the market has not been able to produce a sustainable solution in terms of the quantity and quality of care labour. It has been argued that both the quantity and quality of care are strictly related to the quality of workers and jobs. The overriding policy question is thus whether governments are willing to invest the resources required to provide high quality care. The most difficult challenges will be improving wages, benefits and training opportunities, and enhancing the image of long-term care work, without negatively affecting the demand for care (or the access to care services) of lower income families.

These are the challenges facing the more mature welfare states with fairly developed universal elderly care systems, but struggling with increasing costs and budget constraints. Mediterranean countries, with care regimes still dependent upon the family, have a much longer way to go. Here too, however, there is increasing awareness that the cost of elderly care must be shared more evenly within society; that the increasing complexity of the care sector requires coordination and regulation by the state; and that long-term, viable solutions must be found to guarantee an adequate supply of labour.

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