Filling the gap in long-term professional care through systematic migration policies (Germany, 23-24 October 2013)

Migrant long-term care work in the European Union: Opportunities, challenges and main policy options[1]

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Contents

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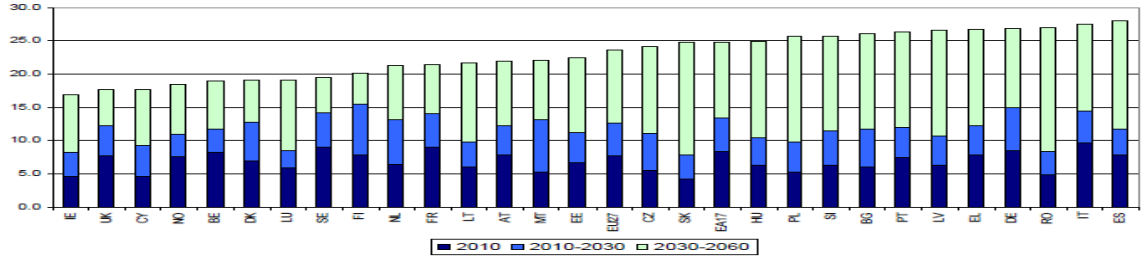
1. Introduction: background and context

A brief overview of the main dimensions to be considered for a comprehensive understanding of the issue at stake is provided. Key trends and challenges will be described with regard to the lack of a skilled workforce in long-term care (LTC) and to migration policy options to address this shortage in European Union (EU) Member States (MSs).

a. **Definitions**: The expression **long-term care** refers to the delivery of a range of services and assistance to people who are limited in their ability to live independently over an extended period of time (EC-EPC 2012). These services may be provided in a variety of settings (in institutions, at home or in semi-residential solutions) and comprise a mix of both health and social components. Most Member States also provide cash benefits that can be used to pay for LTC services (mainly provided by private or informal carers). As a consequence, it is often difficult to define a clear cut boundary between health, social and LTC. This difficulty affects also data availability. For this reason, in this document often we will have to refer to health care staff with no further specification, when data do not allow to distinguish it from LTC staff. With regard to the term **migrant worker**, it refers to a "person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national" (United Nations 1990). According to some states' policies, however, a person can be considered as a migrant even when he/she is born in the country.

b. **The demand for LTC is increasing in Europe**: As a consequence of the combined effect of different factors – and above all the population ageing – LTC needs are expected to continue to grow across Europe in the future (European Commission 2013). In particular, the dependency ratio of the oldest-old (i.e. between people over 80 year old – the population group most likely to require LTC – and those of working age: see Fig. 1 below) is going to increase remarkably across all EU-countries[2] already in the next two decades (EC-EPC 2012:60). Albeit some evidence seems to suggest that this pure demographic effect might be mitigated by improvements in age-related functional impairments (Lypszyc et al. 2012) and/or in older people's ability to live independently (e.g. thanks to a broader and more effective deployment of assistive technologies) (Carretero et al. 2012; Ministry of Health and Social Affairs 2011), a prudential approach recommends considering an increase in the demand for LTC as the most likely scenario for all EU-countries in the future.

Fig. 1: Projections until 2060 of the dependency ratio of the oldest-old (ratio of people aged 80 or older relative to the working age population)



Source: EC-EPC (2012)

[2] If not differently stated, in this paper the term EU will be used to implicitly indicate also Iceland, Liechtenstein and Norway (which belong to the EEA together with all EU countries, except Croatia, which is in a transition phase), as the same migration rules apply to them. Symmetrically, the term "non-EU third countries" will be used to indicate countries not belonging to the EEA.

c. **The response to this increasing demand of LTC is provided in different ways across Europe**: LTC needs are met in single EU countries in very different ways (European Commission 2013). These differences concern, in the first place, the share of LTC provision between **formal** (i.e. contract-based) and **informal** providers (families, volunteers, friends and neighbours). The latter represent in most cases the bulk of LTC provision, even in countries with a well-developed welfare system (Triantafillou et al. 2011). As far as formal suppliers are concerned, strong variations can be identified in terms of their nature (i.e. public, for-profit or non-profit), funding channels (e.g. taxes, social security system, private insurance or out-of-pocket payments) and settings in which care is delivered (i.e. private homes, day-care centres, sheltered houses or institutions) (Colombo et al. 2011; Forder and Fernandez 2011; Lypszyc et al. 2012). In many countries, cash-for-care schemes have been introduced and represent a relevant form of recognising and supporting the role of informal carers (Da Roit and Bihan 2010).

d. **An increasing share of both formal and informal LTC in Europe is provided by migrant workers to overcome existing staff shortages**: No matter how LTC is provided, its delivery relies predominantly on what have been called "**anchored jobs**", i.e. on-location, hands-on work that indicates "face-to-face contact with the final user" (Friedman 2005:238). Although within the EU there are already some examples of "outsourcing" frail older persons to care settings located abroad, so far this remains a rather rare, as well as unpopular and ethically questionable option (Haarhof 2013). As a consequence, the pressure to employ international care workers is likely to increase in countries where the domestic labour market is unable to cover a sufficient number of these positions (Redfoot and Houser 2005:1). The problem of how to fill LTC staff shortages, and the related care staff qualifications, is not new and has been a "major concern" for LTC policy makers in many nations for at least a decade (OECD 2005:13). In parallel, the list of countries affected by this difficulty, that end up relying on migrant care workers to overcome it, is becoming longer and longer (Colombo et al. 2011:174). While a more detailed overview of the situation in selected EU countries will be provided in section 3 (and in the Annex), already a few years ago, in 17 out of the 23 European countries involved in the EUROFAMCARE study, family carers of older people relied on private migrant care workers at least occasionally (Mestheneos and Triantafillou 2005; Bednárik et al. 2013). The last official data estimate that circa 7% of all health care employees in the EU27 are non-nationals (European Commission 2013a:24).

   From a **gender** perspective, in most countries, no matter whether employed by private households or by formal care providers, LTC migrants are usually represented by low-paid, middle-aged women (Rodrigues et al. 2012:79; ILO 2013), who often work on a part-time basis (Fujisawa and Colombo 2009). Finally, as for the **countries of origin** of the care migrant flows, these are mainly represented by Eastern European Member States such as Bulgaria, Romania and the Baltic states, while the main non-EU countries are Serbia, Macedonia, Albania, Moldova, Ukraine, Belarus, South American and Central Asian republics (Vobecká 2013).

e. **Migrant work in the LTC sector can offer several <u>opportunities</u>**: Experts in this field have pointed out that, among the opportunities offered by migrant work in the LTC sector, the most relevant is probably represented by the **financial** dimension. This means, in particular, that (BMWi 2013):

   1. at the ***individual level***: the wage differentials between destination and origin countries represent a relevant incentive for migrants, who remit a consistent

part of their earnings to their own families left behind. The amount and the magnitude over time of such remittances depending, however, upon several factors, such as the type of household, educational level and return plans (Bettin and Lucchetti 2012);

2. at the ***macro level***: LTC staff costs can be kept relatively lower, thus reducing the pressure to increase wages to intercept a workforce supply, which might otherwise be attracted to more appealing labour market segments.

Another positive effect of the presence of migrant work – especially when provided in the home care sector – is the possibility to postpone and reduce **institutionalisation**. This meets, on the one hand, the preferences of European citizens for community care (Eurobarometer 2007:95); and contributes, on the other hand, to further contain overall LTC spending (as residential care is usually more expensive than home care) (OECD 2005a).

Another opportunity provided by migrant care work is the possibility to reduce the **social isolation** characterising many frail older people, especially when they are home-bound. This seems to be the case in most situations (Spencer et al. 2010:41), albeit some studies underline that the employment of a live-in migrant care worker might also lead to a greater emotional and social disconnection of the older person's family, and thus to increased feelings of loneliness in the older care recipient (Ayalon et al. 2012).

f. Migrant care work can, however, pose relevant <u>challenges</u>, too:

Despite the major opportunities offered by migrant care work, this phenomenon raises crucial risks and challenges, too, such as the following:

1. ***Underpaid or irregular employment***: in the light of the "weaker" position of migrant care staff compared to nationals from a legal (especially for non-EU migrants) and linguistic point of view, the risk of irregular or underpaid employment might occur in some countries, especially when the hiring process – or the broader care sector itself (for Germany see Rand 2011; Stolterfoht and Martiny 2013) – is not fully or sufficiently monitored by public authorities (Colombo et al. 2011:176; FRA 2011b; European Commission 2012). This situation is also associated with a higher risk of exploitation, not only from a financial point of view, but also in terms of potential abuse in different aspects of everyday life, especially, but not only (Cangiano et al. 2009), for care work in private households (ILO 2013:95; Lalani 2011; UN-OHCHR 2008);

2. ***Care quality***: relevant differences can exist in the quality level provided by care migrants compared to nationals, especially when the care qualifications of migrants are not fully comparable with those foreseen by the national care system. While in many countries the employment of migrant care workers is seen as positively impacting on care quality (Spencer et al. 2010:37), sometimes the lack of a rapid recognition of migrants' professional qualifications tends to lead to a phenomenon of de-skilling, i.e. migrants end up working – especially at the beginning – at a lower level than the one for which they have formally qualified (Colombo et al. 2011:175). A related aspect to be considered in this respect is that the concept of "care quality" might also be culturally sensitive, so that in some cases care recipients are not necessarily sharing the same view as migrant care workers of what "good care" should look like (Spencer et al. 2010:61-65);

3. ***Health and wellbeing of migrant care workers***: many migrants often suffer from psychological distress for reasons related to being migrants, which local health care services are not always able to properly diagnose and treat

(Tolstokorova 2007; Watson 2004). This might be accentuated in case of irregular/underpaid employment (FRA 2011a);

4. ***Care drain***: a crucial dimension to be considered refers to the impact on their left-behind children and/or older parents (Tolstokorova 2007; HelpAge International 2008; Pantea 2012). In many cases the emotional-social deprivations and deviant behaviours suffered by the latter might overcome the economic benefits deriving from the financial remittances they receive (De Soto et al. 2002; King & Vullnetari 2006; Mudrak 2011). This also has consequences at the macro level, as it might imply a heavier burden on the welfare services in the source countries (Piperno 2010), thus posing a clear transnational challenge to national-only care policies (Zechner 2010). Another related aspect, at the macro level, is that educational costs originally sustained by source countries to train migrant care workers end up benefiting mainly destination countries, while source countries' labour market might start suffering from the lack of skilled workers (Vobecká et al. 2013).

g. Migrant care work as "meeting place" of different policy areas: In light of the above described opportunities and challenges, it is evident that **a comprehensive conceptual framework is needed** to inform policy attempts to govern this complex field in a sensible and respectful way for all involved parties. In this respect, it should be acknowledged that governing migrant work in the LTC sector implies, first of all, a parallel intervention in at least **three different policy areas** (Lamura et al. 2010):

1. ***Migration policies***: according to the degree of regulation, and oversimplifying things somewhat, we can distinguish two main types of "regimes": those relying on "**managed**" migration schemes and those based on "**unmanaged**" migration routes (Rostgaard et al. 2011)[3]. The first usually considers highly-skilled migration as desirable and regulates and controls flows quite tightly, so that undeclared migration is quite uncommon, as migrants are usually employed by organised providers (i.e. home care or residential care organisations). Unmanaged migration regimes, on the contrary, usually tolerate or even explicitly allow low-skilled migration, due to a lack of controls, rather than explicit rules, and use ex-post legalisations to regularise the position of the many undeclared migrants living in these countries, who are more often directly employed by private households;

2. ***LTC policies***: here, too, we can distinguish between highly regulated LTC regimes and less regulated ones (Da Roit and Le Bihan 2010). The first are based on in-kind care services or strongly regulated cash-for-care schemes, rather than on informal care, and usually grant to migrant workers the same protection as that of the local workforce. The less regulated regimes tend to be based on unrestricted cash-for-care schemes, to rely **explicitly** on informal care and **implicitly** on the unregulated, low-skilled care work provided by migrants, who in everyday practice cannot always count on the same rights protection granted to native workers;

3. ***Labour market policies***: here we can distinguish (Simonazzi 2009), on the one hand, more professionalised regimes (where qualification requirements limit the access of low-skilled migrants, who can however profit from the

[3] Examples of the first kind can be found in Continental Europe (e.g. Austria and Germany), but also in Scandinavia (e.g. Denmark), as well as in the UK. Examples from outside the EU are provided by Canada and the US, but also by Israel. This latter country seems to represent an exception in the Mediterranean area, since most countries in this region (e.g. Italy, Greece, Spain and, increasingly, Turkey) are more likely to reflect the unmanaged type of migration regime (Lamura et al. 2010).

existing – albeit limited – career opportunities) and less professionalised labour markets (where no or very little requirements are needed to access most LTC jobs, because these are provided in the grey market in the form of mainly low-skilled tasks and without any career opportunities). A key distinction to be considered is the one between migrant workers **hired by public or private care organisations** – a pattern which is more relevant, as we have seen, in North-Western Europe – and those **privately employed by families** in Southern and Continental Europe (see Table 1). The role of care recipients, funding channels and responsibility for quality controls differ substantially between the two situations. Crucial is also the role played by the **professional and vocational training** required/offered. It is therefore necessary to weigh the implications of all these aspects when making decisions in this area;

Table 1: Main differences characterising the role of migrant LTC workers when employed by LTC organisations and by private households

Dimension	**Migrant's main type of employment**	
	As employees of LTC organisations	*As workers privately employed by care recipients' families*
Countries in which this form is prevalent	Northern & Western Europe	Mediterranean & Continental (+ Eastern) Europe
Prevailing role of care recipients	Client/service user	Employer
Main source of funding	Public LTC funds	Out-of-pocket + cash-for-care schemes
Control on care quality mainly performed by:	Care provider or funding body	Care recipient
Level of professionalisation and vocational training	Generally higher	Generally lower

Source: Lamura et al. 2010

h. **Implications of migrant care work in source and destination countries, at the micro, meso and macro level, and in the short and long-term**: A comprehensive approach to migrant care work should furthermore be able to identify the potential impact of different policy options at national, EU and international level, in terms of opportunities and challenges, for both **source and destination countries** at a macro, meso and micro level (Buchan 2007). As shown in Table 2, at a **macro level**, this would mean, to give an example, considering that the advantage of solving LTC staff shortages in destination countries might be offset by negative effects on the workforce in source countries, or by difficulties in integrating migrants and their families in destination countries themselves. At a **meso level**, while families might profit from financial remittances, the care and educational gaps caused by the migrants' absence on their parents and children left-behind might become a serious social problem in source countries. At a **micro level**, improved working opportunities experienced by both native and migrant LTC workers might be traded off by possible situations of social discrimination and exclusion. Ideally, it should be added, such an analysis should take into account potential effects both **in the short and in the long-term**, as the time dimension is a frequently neglected aspect of migrants, on the one hand, but an often intentionally used governance tool by policy makers (Lamura 1998).

Table 2: Opportunities and challenges raised by migrant LTC work, by involved policy levels and actors

Level	Country	Opportunities	Challenges
Macro (national or international)	*Destination*	- solution of LTC staff shortages - saving education/training costs	- efficiency (needs for training) - ethical issues (care drain) - social integration of migrants
	Source	- remittances - up-skilled returnees - reducing unemployment	- staff shortages - costs of "lost" education - social costs of supporting families left-behind
Meso (family / care organisation)	*Destination*	- solution of LTC staff shortages	- managing "ethnic diversity of staff"
	Source	- remittances to left-behind families - up-skilled returnees	- staff shortages: loss of skilled staff & costs of recruitment - lower morale of staff left-behind - care gaps of kin left-behind
Micro (individual)	*Native LTC workers (in destination)*	- reduced work load/pressure	- facing higher "ethnic diversity" of colleagues
	Migrant LTC workers (destinat.)	- higher wages and career opportunities	- possible discrimination - integration in local society
	Left-behind LTC worker (in source)	- possible improved work opportunities	- increased work load - lower morale

Source: own adaptation from Buchan (2007)

i. **Main approaches at national, EU and international levels**: The above framework is a useful conceptual tool to inform the decision making process to select among different policy options, which, despite the complexity of the issue, can essentially be grouped into **two main approaches** (Buchan 2007; Vobecká et al. 2013): active or managed (i.e. attempting to control migration flows); and passive or unmanaged (i.e. trying to adapt to them). In light of the freedom of movement currently in force within the EU, and of the strong economic incentives presently existing for workers from many emerging non-EU third countries to migrate towards the wealthiest EU Member States, a mainly **passive or unmanaged approach** would clearly result in a substantial, immediate flow of migrants towards such countries. While this might provide a quick response to the care staff shortages affecting the latter, it would at the same time pose relevant problems, already in the short term, especially with regard to the professional qualification of such staff and its linguistic and cultural ability to be integrated into destination countries, and in terms of care drain phenomena in the countries of origin, where however remittances might have a financially positive impact. A rather **active or managed approach** should instead recognise the supranational relevance of migration's consequences for both sending and receiving countries, and thus build collaborative international policies as the only way to take systematically into consideration both sides' interests (Vobecká 2013). This would allow considering the perspective of both source countries (e.g. improving socio-economic conditions to reduce emigration of skilled staff and ensuring a correct transfer of remittances) and receiving nations (e.g. removing barriers to skilled care migrants and strengthening their

integration), and developing systematic international decision making processes to monitor and govern migration and control undesirable outcomes. In most cases, a **combination of the two approaches** is likely to occur, with national or even regional variations.

2. Setting the scene: overview of policy developments related to addressing the lack of skilled workforce in LTC through systematic migration policies at European and international levels

2.1. The place of the issue in the European agenda

To contextualise the issue at stake within the European agenda, it is useful to follow the three relevant policy areas identified in the previous paragraph ("section g": migration, LTC and the labour market). Preliminarily, however, this section will focus on the possible links existing with the overall Europe 2020 strategy.

a. Intersections with the overall "Europe 2020 strategy" and relevance in the context of the "Compact for Growth and Jobs"

1. **Europe 2020** is the EU's ten-year strategy addressing the shortcomings of the EU growth model and creating the conditions for a smarter, more sustainable and more inclusive growth pattern[4]. Five key targets have been set for the EU to achieve by the end of the decade, covering: employment; education; research and innovation; social inclusion and poverty reduction; and climate/energy. Europe 2020 is linked to the new financial instrument of the EU, called Horizon 2020, running from 2014 to 2020, among whose targets aims at reaching an employment rate of 75% among the population aged 20-64. In this context, the "**Compact for Growth and Jobs**", adopted in June 2012[5], provides a coherent framework for a more coordinated action at national, EU and Euro-area levels, with the objective of "creating jobs and a genuine European labour market". To tackle the economic and social challenges of high unemployment and demographic change, the European Commission (EC) has moreover launched an **Employment Package**[6], setting out key measures to support job creation, restore the dynamics of the labour market, enhance EU governance and accelerate work on the portability of pension rights.
2. All these initiatives are relevant, since LTC can be considered as an opportunity for job growth and the future supply of jobs for the low skilled. As the LTC sector is a major source for female, mainly part-time employment in many EU countries – these workers being often hired after a period of economic inactivity (van der Velde et al. 2010), frequently in mature age (Martin and King 2008) –, this sector represents a strategic area to create occupation for both the migrant and the non-migrant labour forces. **EU Structural Funds**, including the **European Social Fund**, can play an important role in this area, by paying more attention to health and social inclusion issues, especially if

[4] *Communication from the Commission - Europe 2020 - A strategy for smart, sustainable and inclusive growth,* COM(2010) 2020 final.
[5] Available at http://ec.europa.eu/europe2020/pdf/compact_en.pdf
[6] "Towards a job rich recovery", COM(2012) 173 final, "Exploiting the employment potential of the personal and household services", SWD(2012) 95 final and "Action Plan for the EU Health Workforce", SWD(2012) 93 final.

they are made more easily accessible to potential users (European Commission 2013).

3. In this respect, the reform of the **European Job Mobility Portal** (**EURES**), which is currently under way, might improve the recruitment and placement platform at the European level, as indicated in the "Compact for Growth and Jobs", thus fostering mobility of EU nationals as well as supporting the management of economic immigration from third non-EU countries in the LTC sector. In European cross-border regions, EURES plays an important role in providing information about and helping to solve all sorts of problems in cross-border commuting that workers and employers may experience.

b. Intersection with EU migration policies

1. The challenge of filling the gap in the LTC workforce through systematic migration policies is, clearly, influenced by the European Commission's approach to the migration policy. In this policy area, as anticipated, we should distinguish between EU and non-EU migration flows. The freedom of movement for **EU workers**, in fact, is a policy chapter of the EU acquis and is regulated by Article 45 of the European Treaty (ex 39 and 48).

2. As for **non-EU migration**, despite some progress towards a more integrated EU system, this area remains largely dominated by national policies (Cangiano 2012). Indeed, in 2005 the EC tried to move toward a greater integration in this area by adopting a *Green Paper on an EU approach to managing economic migration* (European Commission 2005) to launch an in-depth discussion on this topic, which drew the attention to the possible advantages of the immigration of third-country nationals into the EU. Three years later, the aforementioned *Green Paper on the health workforce* (European Commission 2008) stressed the importance of promoting "social and ethnic diversity in recruitment", but acknowledged at the same time the more limited policy options available for non-EU nationals compared to the free movement rights of EU workers. The main message emerging from these attempts is that EU countries have been reluctant in giving up their national sovereignty in governing labour migration until recently, under the assumption that sufficient flexibility was necessary to meet the different needs of national labour markets (Pastore 2012).

3. Already in both Green Papers, however, the EC underscored the importance of "**ethical recruitment**", especially for sectors particularly vulnerable to brain drain, including the health care sector, as severe health staff shortages were already affecting some countries, particularly in Africa. To this end, the EC proposed a series of initiatives[7], of which two, after long discussion, emerged in recent years:

   - the ***Blue Card Directive*** aims at attracting highly qualified migrants and strengthen Europe's competitiveness by means of a harmonised fast-track procedure and common criteria (i.e. a work contract, professional qualifications and a minimum salary level) for issuing a special residence and work permit called the "EU Blue Card". This Directive, adopted in May

[7] The EC proposed, at that time, a series of initiatives on legal migration, in four complementary policy areas (*Communication from the EC "Policy plan on Legal Migration"* (SEC(2005)1680): 1) a proposal for a directive on the conditions of entry and residence of highly skilled workers; 2) a proposal for a directive on the conditions of entry and residence of seasonal workers; 3) a proposal for a directive on the procedures regulating the entry into, the temporary stay and residence of Intra-Corporate Transferees (ICT); 4) a proposal for a directive on the conditions of entry and residence of remunerated trainees.

2009, promotes ethical recruitment standards to limit or stop active recruitment by EU States in developing countries in order to limit the damages of the "brain drain" phenomenon. The EU Blue Card is demand-driven and based on a renewable work contract with a validity between one and four years;

- the ***Single Permit Directive*** was adopted in December 2011 to create a set of rights for non-EU workers legally residing in an EU State. The Directive is applicable to non-EU nationals with authorisation to reside or work in the EU, independently of their initial reason for admission. It provides for a single application procedure to obtain a single residence and work permit, and ensures a set of rights for all non-EU workers in a number of key areas (working conditions, education, vocational training, recognition of diplomas, social security, tax benefits, access to goods/services and housing). In practice, this enables non-EU workers to move from an occupation to another following labour demand, including the strategic sector of LTC.

4. Other relevant EU recommendations in the area of migration are included in the *Green Paper on the health workforce* (European Commission 2008), where, while underlining the importance, within single countries, of promoting "social and ethnic diversity in recruitment", a distinction is proposed between the policy options to be followed within the EU and towards non-EU third countries. **Several strategies are recommended to single Member States**:
   - ***Integration of migrants***: while the 2003 *Communication on Immigration, Integration and Employment* (COM(2003) 336 final) had already stressed that access to the labour market is crucial for the integration of third-country nationals, the 2005 *Communication on a Common Agenda for Integration* (COM(2005) 0389 final) set up the premises for a broader framework for the integration of third-country nationals in the EU across various fields, covering employment, urban policies and education, to be achieved via joint efforts across a range of policies and through the support of educational, training and cultural initiatives. For the period 2007-2013 the Commission proposed a new targeted solidarity instrument, the European Fund for the Integration of third-country nationals[8], with the specific objective – complementary to those of the European Social Fund (ESF) – of supporting national and EU initiatives that can facilitate the integration of non-EU immigrants into European countries;
   - ***Cooperation with countries of origin***: the European Commission identified this as a key area to develop initiatives offering "win-win" opportunities to countries, of origin and of destination, and to labour immigrants. These can easily include actions aimed at monitoring the migration of skilled LTC workers so as to identify sectors and countries of origin at risk of significant brain drain phenomena;
   - ***Circular and return migration***: the relevance of this issue as a tool to promote development in emerging countries has been highlighted by the *Communication on Maximising the Development Impact of Migration*

[8] With a budget of 825 million Euros for the period 2007-13, the EIF, which all EU countries except for Denmark adhere to, is primarily targeted at newly arrived immigrants. It supports EU countries and civil society in enhancing their capacity to develop, implement, monitor and evaluate integration strategies, policies and measures, as well as their exchanges of information and best practices and cooperation on integration issues (http://ec.europa.eu/dgs/home-affairs/financing/fundings/migration-asylum-borders/integration-fund/index_en.htm).

(COM(2013) 292 final). In this respect, the *Directive on the status of long-term residents* (Council Directive 2003/109/EC) offers the possibility for Member States to allow returning migrants to retain this status for longer periods, however requiring feasibility studies to identify new measures (e.g. long-term multi-entry visas for returning migrants or simplified procedures for former migrants to be given priority and obtain new residence/work permits in the former host country). Other possible measures are the establishment of a database of third country nationals who have left the EU at the expiration of their temporary residence/work permit and the design of temporary migration schemes to maximise benefits for all parties (i.e. labour needs in Member States, development of emerging countries via return migration and training and other opportunities for migrants);

- ***Training in the countries of origin***: according to the above mentioned European Commission *Communication* (COM(2013) 292 final), professional training and linguistic courses in the country of origin could help migrants to better adjust to the labour needs in the EU, thus facilitating their opportunities to find legal employment. However, the political opportunity and the technical/financial feasibility of supporting, with EU funding, the establishment of adequate training structures to this purpose needs to be further explored.

c. Intersection with EU LTC and welfare policies

1. The European Commission recently adopted a *Communication on Social Investment for Growth and Cohesion* (COM(2013) 83 final), which also gives guidance on how to use tools such as the European Social Fund. The Commission monitors closely Member States' social protection systems through the European Semester and formulates country specific recommendations. To this purpose, the **Social Investment Package** (SIP) identifies several challenges for more efficient and effective social policies, including demographic ageing and the shrinking of working age populations. Among other things, the SIP includes examples of how LTC challenges can be tackled through prevention, rehabilitation and more age-friendly environments, and by developing a more efficient care delivery. It briefly addresses the shortage of a health and LTC workforce, by suggesting the opportunity of country-level incentives for boosting employment in 'white coat jobs' and improving working conditions in this area. The European Structural and Investment (ESI) Funds, in particular the ESF, as well as PROGRESS 2007-2013, the Programme for Social Change and Innovation (PSCI) 2014-2020 and the Fund for European Aid to the Most Deprived (FEAD) can be important instruments for implementing the strategy set out in the SIP.

2. A recent *Commission Staff Working Document* (European Commission 2013) does not seem to identify migration as a priority option to tackle the challenges related to growing LTC needs, as these should be ideally met mainly through a mix of measures to both reduce care demand and to increase care delivery productivity via organisational, quality and ICT-based innovations. Albeit not explicitly mentioned in this document, to increase and maintain productivity in the LTC sector it is essential to invest in the shrinking care workforce. A crucial tool to activate EU-wide actions in this respect is represented by the **Open Method of Coordination** for social protection and social inclusion (Social OMC), which provides a framework for national strategy

development, as well as for coordinating policies between MSs on issues relating – among other topics – to LTC[9].

3. The **identification of one or more indicators via the OMC** to monitor the developments occurring in the LTC workforce can foster more focused and harmonised initiatives in this field, with an evident impact on the role assigned to migrant care work at a national and EU level. In addition, **Horizon 2020** can promote studies aimed at identifying the most effective ways to ensure an adequate provision and/or an ethical recruitment of migrant LTC workers (e.g. by testing the effectiveness of international recruitment agencies and/or of bilateral agreements), as well as the strategies for their inclusion and retention.

d. Intersection with EU labour market and training policies

1. So far, while no specific EU policy has systematically and comprehensively dealt with the issue of LTC and of the recognition of professional qualifications of non-national LTC workers, the **directive 2005/35/EC** has been providing a framework for the mutual recognition of qualifications of health professionals for several years. This concerns in particular those of the so-called "sectoral professions": doctor, nurses, midwives, dentists and pharmacists. This directive sets common minimum standards across the EU regarding duration of education and training of health care staff, thereby implying that many Member States might require migrant care workers to have additional education to be recognised at their professional level (Tjadens 2007). Outside of this health staff related framework, it is mainly national or regional regulations that define the **minimum requirements needed to qualify as a LTC worker**, although other training **schemes – often short-term** training programmes provided by employers – also play a role, often in the form of on-the-job training[10]. These different regulations clearly affect the patterns of migrants' entry into the LTC workforce, and the persistence of such discrepancies represents a barrier hindering both intra-EU and extra-EU mobility of LTC labour.
2. The main instrument, at the EU level for funding actions in the areas of education and training is the **Lifelong Learning Programme** (LLP). It funds a range of activities, including exchanges, study visits and networking, by means of two main sub-programmes which can be used to address the needs of migrant LTC staff, which are the "Leonardo da Vinci" (for vocational education and training) and the "Grundtvig" (for adult education). Other projects in areas that are relevant for policy co-operation can be funded and supported through the "transversal" part of the programme. As the *Commission Staff Working Document on LTC* (European Commission 2013) suggests, the LLP and its successors "will continue to provide funding for the acquisition of skills and competences by carers, whether formal or informal, as

[9] For a detailed description of the methodology applied by the OMC see http://europa.eu/legislation_summaries/glossary/open_method_coordination_en.htm.

[10] Apart from nurses – who typically qualify in an often certified or accredited vocational education – some countries have no targeted education for LTC workers (e.g. Hungary and Poland). Other countries have, especially for lower-level workers, programs that combine some theory with practical training. In most countries, initial vocational training for LTC is publicly financed, although in some MSs there is a mix of public programs with national certification, and private funding. For lower-skilled care workers, standardization of qualification is often lacking and many LTC workers do not have such qualifications. Usually LTC workers have lower qualifications than health care workers (Fujisawa and Colombo 2009), and those working in institutional care have higher qualifications than those working in home care.

well as funding and tools for the recognition and validation of the skills acquired".

2.2. Recommendations from other international institutions

a. A well articulated and evidence-based set of considerations on possible policy options in this area is proposed by the **Organisation for Economic Co-operation and Development** (OECD). While it recognises that, due to the growing constraints in public spending, previous fears about care staff shortage are now being substituted by concerns about a possible oversupply in some countries (e.g. in the UK), this institution underlines that optimal health workforce planning efforts at the national level should consider more extensively neglected dimensions such as wage levels and health expenditure, as well as staff substitution strategies both in "horizontal" (i.e. between general and specialised care professionals at the same level) and "vertical" terms (i.e. between care professionals belonging to different levels) (Ono et al. 2013). On the whole, OECD's guidelines for care migration are based on **four main pillars** (Colombo et al 2011:197; OECD 2009): 1) efficient issue, processing and delivery of work permits in numbers reflecting estimated care labour needs; 2) development of tools to match migrant workers to care jobs, both in destination and source countries; 3) development of channels (e.g. registers) that allow both sides to verify the trustworthiness of potential employees/employers; 4) implementation of effective workplace enforcement procedures.

b. The **World Health Organisation**'s *Global Code of Practice on the International Recruitment of Health Personnel* (WHO 2010) probably represents the most rigorous and comprehensive attempt to provide a framework to ensure an ethically acceptable international recruitment of health care staff. It recognises, on the one hand, the individual right to the highest standard of health, to be ensured via an equitable access to health personnel, both in destination and source countries; and, on the other hand, the individual right to migrate, trying however to suggest ways to mitigate the negative effects of migration and maximise its positive effects, particularly in source countries. Its main recommendations include references to (WHO 2010a): 1) the ethical recruitment of health staff from developing countries (by discouraging it when it might cause staff shortages there); 2) health systems sustainability (by stating that countries should meet their staff needs primarily via their own human resources); 3) fair treatment of migrant care staff at all stages (training, recruitment, career); 4) collaboration between destination and source countries to achieve mutual benefits; 5) technical and financial support of developing countries; 6) improvement of data gathering and information exchange (for an effective implementation of the code).

c. Finally, it is worthwhile to mention a recent **World Bank** report (Mattoo and Subramanin 2013), which suggests that **a more "bilateral" view of migration flows** would benefit health and LTC service users in traditional, wealthier destination countries, if they only could more easily access cheaper services in emerging countries. Three steps are suggested as helpful in this respect: removing barriers to the cross-border portability of health care insurances; facilitating the currently complicated recognition of qualifications obtained abroad; and the liberalisation of foreign investments in the care sector. The latter aim, in particular, seems far from being a reality even in the EU's "common market", which the difficulties experienced so far by German residential LTC providers in Austria clearly show (Leichsenring 2013).

3. The approaches adopted by selected European countries in tackling this issue

A comparative overview is provided of the main national policy responses adopted by selected countries with regard to the issue. The analysis will focus, in particular, on the initiatives undertaken by different countries to use their potential of national and international professionals in LTC and on their approaches to systematic migration policies in this field. For this purpose, reference will be made to the main ***welfare state typologies existing in Europe*** *- Scandinavian/Nordic, Liberal, Mediterranean, Continental and Post-Communist (Degavre et al. 2012; van Hooren 2011; Tache et al 2011) – as this can facilitate a deeper understanding of commonalities and differences among various approaches.*

a. Firstly, it should be acknowledged that, today, the extent of this phenomenon has reached the level of a "structural" response in some EU Member States. This is the case, in particular, of **Mediterranean countries** with a "familistic" approach to LTC like Italy, Greece and Spain (Lamura et al. 2010a). Interestingly enough, these countries are also among those where, due to the current economic and financial crisis, the care staff shortage is accompanied by a remarkable increase in youth unemployment, whose rate now varies from over 35% in Italy to 53-55% in Greece and Spain, against a EU-average of 23%, which is already doubly as high as that among adults (Eurostat 2013).

b. To some extent, migrant care work is also present in **Continental welfare states** such as Austria and Germany (Bednárik et al. 2013). In all of the above countries, in many cases the majority of migrant care workers are employed by private households, especially in the Mediterranean area, without a regular contract (FRA 2011b). A different pattern characterises **Western (e.g. UK and Ireland) and Northern European (e.g. Scandinavian) countries**. Here care migrants are less numerous and more frequently part of the regular workforce employed by formal care organisations (Colombo et al. 2011; Rostgaard, Chiatti & Lamura 2010; Rodrigues et al. 2012; Spencer et al. 2010), although this seems to be changing in the UK, where live-in migrant care workers are becoming more recurrent due to the increased role played by cash-for-care payments (Christensen and Guldvik 2013). In fact, a very large part of recent increases in institutional care employment in the EU is accounted for by foreign-born workers (Colombo et al. 2011:195).

c. As it is not possible to assess in detail the situation of all 28 single Member States within the scope of this paper, the following analysis will focus on providing an in-depth overview of the approach adopted by one country for each of the **main welfare state typologies existing in Europe**: Scandinavian/Nordic (Denmark); Liberal (UK/England); Mediterranean (Italy); Continental (Germany); and Transition (Romania). For each of the selected countries, a structured synopsis is presented in the Annex, which includes the following sub-sections: 1) trends in LTC-demand; 2) trends in LTC staff provision; 3) legal framework; 4) policy options to increase the supply of domestic LTC staff; 5) policy options for the recruitment of migrant LTC workers; 6) gender aspects. The main trends characterising the five selected countries are summarised in Table 3 below.

Table 3: Overview of national approaches to LTC staff migration in selected EU countries

	Trends in LTC		Legal framework for workers migration from		Policy options to increase domestic LTC staff	Current policy in LTC migration from		Major gender-related issues
	demand (a)	staff shortage (a)	EU MS	non-EU MS		EU MS	Non-EU MS	
	1	2	3a	3b	4	5a	5b	6
Denmark	++	++	free	Only highly skilled	Increase employment of existing migrants	Local recruitment from DE, SE & IT (f)	No active recruitment	Lower employment rates among female LTC migrants
England	++	+ / ++	free (a)		Increase wages and quality of LTC work	No active recruitment		
Germany	+++	+++	free (b)	None, but Croatia (b)	Increase full-time and female LTC workers	Limited bilateral programs	Plans to recruit from Asian countries	
Italy	+++	+	free (c)	Mainly low skilled (d)	No specific policy	No active recruitment (but ex-post legalisation)		Lower wages for women in irregular LTC jobs
Romania	++	+	free	Mainly low skilled and irregular (e)	Increase both wages and role of NGOs	No active recruitment		

Notes:
a) +++: high/increasing; medium/stable; high/decreasing;
a) Temporary restrictions apply to workers from Bulgaria and Romania (until the end of 2013) and from Croatia (until 30th June 2015).
b) Temporary restrictions apply to workers from Bulgaria and Romania (until the end of 2013), and from Croatia (until 30th June 2015), albeit a bilateral agreement allows Croatian citizen to work in Germany if they possess a qualification as elder care nurse.
c) Temporary restrictions apply to workers from Croatia (until 30th June 2015).
d) Since August 2013 non-EU nationals can apply also for permanent positions in public organisations.
e) A mobility partnership with Moldova aims at reducing illegal migration to Romania from this country.
f) DE: Germany; IT: Italy; SE: Sweden.

Source: country reports in the Annex; Tjadens et al. (2012); Colombo et al. (2011)

d. As the contents of Table 3 clearly show, national approaches in the field of LTC staff migration policies differ in many respects, partly as a consequence of different drivers and starting conditions. While the Annex contains details for each of the chosen countries, a primary factor to be considered concerns the **intensity of LTC demand**, which is currently highest in Germany and Italy. However, these two countries show a very different approach to **LTC staff provision**, as the former is currently recording a remarkable shortage, while the latter reports almost no difficulties in this respect, with other countries in an intermediate position (excluding Romania, which is similar to Italy). The **legal framework** concerning EU-migration is of course similar, despite some minor differences on how temporary restrictions have been dealt with in the past, which soon will no longer be relevant, while major differences can be observed with regard to non EU-migration. While Denmark and England have a focus on highly skilled migrants, Italy and Romania are concerned mainly with low skilled workers and Germany is implementing the less "open" approach to non-EU migration.

e. **Policy options** to increase domestic LTC staff vary among countries, but what is most relevant for this paper's purpose is that the only country currently planning to perform an active recruitment of non-EU care migrants is Germany. Finally, major **gender-related concerns** in Denmark, England and Germany regard the lower employment of female LTC migrants, while in Italy and Romania a relevant issue is the gender-gap in wages, disadvantaging women in irregular LTC jobs.

4. Thematic links to earlier policy debate and research

*The issue of migrant work in the LTC sector has been debated, albeit not as a main focus, in recent **Peer Reviews**. It should be underlined that this was not the case until just a few years ago, as still in 2007 it could be stated that "Member States, as far as can be seen from their most recent National Reports in the OMC framework, tend to ignore their international workforce" (Tjadens 2007).*

a. Less than one year ago, the Peer Review on ***"Age friendly goods and services - an opportunity for social and economic development***" highlighted that innovative approaches are required to take advantage of the opportunities offered by population ageing (Zaidi 2013). To this end, one main area in which actions are needed concerns the promotion of older people's social participation, among other things, by supporting and relieving them in fulfilling family care obligations. In this respect, some peer countries, particularly Italy, pointed out that this goal could be achieved also by "formalising informal care arrangements", such as those involving migrant workers, who are employed by many Italian households, as well as in Spain and other Mediterranean countries, without any employment protection.

b. While the Peer Review discussed above touched upon this issue only marginally, more space and attention was paid to this topic in 2011 by the one entitled **"In *search for ways to deal with expanding care needs and limited resources"*** (Riedel 2012). The findings reported by this Peer Review confirm, in the first place, that in a EU characterised by a variety of models for LTC provision, such a labour intensive sector is characterised by low-pay, low-status and very demanding work, which leads to high turn-over rates and recruitment problems in several countries.

   1. This might be the case less so **in well developed welfare systems**, such as in Sweden, where on the demand side, the need for help by older people is kept under control by improved housing standards and the large deployment of assistive technologies and, on the supply side, with the government strengthening competences of unskilled home care staff and increasing user's free choice by allowing private providers. Another unusual situation can be observed in Luxembourg, where higher wages minimise the difficulty in attracting non-resident workers, who represent a large share of migrant LTC workers. Here, an interesting innovation concerns the attempt, currently under development, to tackle language problems in the process of delivering care through the implementation of multi-language software systems for managing care data.

   2. Despite these privileged situations, the reality of many **Continental and especially Southern European EU-countries** shows that staff shortages have been increasingly tackled via migrant workers with uncertain economic and legal prospects – mainly employed as domestic helpers – who, today, make up a considerable amount of the overall LTC workforce in these countries.

3. In light of this situation, especially large, **international NGOs** stress the importance of improving payment and working conditions to increase the attractiveness of LTC jobs for both national and migrant workers (e.g. Age Platform Europe), on the one hand, and of overcoming the complications posed by current legal channels for migration into the EU, which give preference to highly skilled workers (e.g. Caritas Europa), on the other hand. The latter approach, in particular, is deemed to be unable to fully respond to the projected needs in the LTC sector, thus contributing to keeping a large share of foreign-born LTC workers in an illegal position across Europe, especially in informal domestic care settings.

c. The lessons emerging from the above reported experiences as well as from the discussion which developed within this Peer Review allow us to formulate some **crucial considerations, as possible starting points to build upon.**

1. The first concerns the idea that current care labour shortages should be addressed only by an **overall strategy**, aimed at improving access opportunities to the labour market, recognition of professional qualifications, recruitment and training procedures, but also at increasing retention of LTC workers. This implies, to a certain extent, the regulation of transnational recruitment agencies, in order to eliminate the abuse and trafficking of workers denounced in some EU countries.
2. Wide consensus can be observed regarding the suggestion that **major improvements in the quality and prestige of care jobs are needed** across Europe in terms of pay, reputation, qualifications, working conditions and career opportunities. This should be achieved via efforts to strengthen the education as well as through a proper labour market policy, more effectively addressing the widespread problem of illegal, mostly migrant, care work. Less unanimous was the opinion on what should be the "right" balance between skilled and unskilled LTC workers to achieve an acceptable level of care quality.
3. Summarising, the **key messages** emerging from previous Peer Reviews suggest that, before public expenditure on LTC provision is increased, appropriate efforts should be made to improve the available information systems, in order to obtain more precise and timely estimates of LTC gaps. Secondly, the effectiveness of current LTC service provision systems should be enhanced through new technologies. And thirdly, the domestic supply should be increased from different formal and informal (e.g. through an increased contribution from male and older workers), public, profit (e.g. via more full-time female workers) and non-profit sources (e.g. volunteers).

5. Assessment and brief summary of the main features of the policy under review[11]

a. Background

1. **The problem at stake**: in many EU countries, demographic trends are reducing the working age population and increasing the number of older people needing LTC. In some countries (e.g. Germany), the supply of care workers can hardly be met via national skilled workers, as re-training or increased labour market participation of women, older workers and non-employed persons are not deemed to be sufficient in this respect, nor

[11] This section has been drafted taking into account the information provided by the Host Country paper (BfG 2013).

exclusively through additional increases in the efficiency of care organisations.

2. **The proposed solution**: the recruitment of skilled care workers from abroad – while it cannot represent a sustainable stand-alone strategy to solve current workforce shrinking trends (Peschner and Fotakis 2013) – could at least partially compensate for staff shortages and positively affect the LTC sector in destination countries, as well as benefit source countries, when these are characterised by a demographic and/or workforce oversupply.

b. Legal differentiation between EU member states and non-EU countries

1. **Legal differences**: Fundamental differences exist between EU and non-EU (third) countries in terms of legal frameworks for migrants, especially with regard to access to the labour market and recognition of professional qualifications:
   - EU-member states: no special working permit is necessary any longer, and reciprocal recognition of professional qualifications is ensured[12];
   - non-EU third countries (outside the EEA or of bilateral agreements): the access of staff to single countries' labour market is subject to a national scrutiny reserve;
2. **National recruitment policies**: they follow the political direction taking place at the EU-level (e.g. blue-card initiative or EU commercial agreements with non EU-countries) or are based on bilateral negotiations (e.g. EU mobility partnerships[13]).

c. Political, cultural, ethical and linguistic aspects

The following factors can play a crucial role in the structural recruitment of LTC staff (practical examples and references are provided for Germany):

1. **Politically:** the presence of over 3 million unemployed Germans could not prevent the severe care staff shortages being experienced in the country, especially in rural areas, despite the activation policies adopted in the last years and the abolition of the national scrutiny reserve in 2011. Today German public opinion seems to be more in favour of foreign LTC staff recruitment than a few years ago, despite the not always positive "Gastarbeiter" experience of the 1955-73 period.
2. Still, some **cultural reservations** exist in the public opinion, especially in light of the high number of foreign medical doctors in hospitals (who in some remote clinics in Eastern Germany represent the majority of medical staff). This might be challenging with respect to the relationship of trust between care staff and patients, and to the public's hesitance in accepting the idea that key positions in the health sector might be allocated to foreigners. Another aspect to be considered is the impact of the cultural background of the migrants themselves as, for instance, religious affiliation can have a remarkable effect on the propensity to join the (LTC) labour market, especially among women (Pastore and Tenaglia 2013).
3. **Ethical doubts** regarding the effects of recruitment concern above all the risk of draining the health care systems and the educational investments in the source countries. To this end, it is useful to distinguish between the

[12] The only exceptions remaining are the restrictions imposed in some countries for citizens from Bulgaria and Romania (until December 2013) and from Croatia (potentially until 2020).
[13] For more details on these partnerships refer to: http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/international-affairs/global-approach-to-migration/specific-tools/index_en.htm.

recruitment of skilled staff and that of untrained entrants, as the latter strategy[14] might bypass at least some of these ethical issues.

4. **Language** represents another frequent practical problem, as care professions can be meaningfully performed only when there is "sufficient" carer-patient communication. The level of required linguistic skills is decisive for up-front costs.

d. Recruitment and other related costs

1. **Well-managed migration programmes are costly**: An intensive and country-specific, culturally sensitive preparation and supervision of projects of structured migration is very important. Previous experiences show that this has an impact on the costs of the programme to be carried out.
2. **Cost participation models**: In some pilot projects conducted in Germany (BfG 2013), these additional costs were covered mainly via general federal tax revenues. For a future, more structural solution, a cost participation by employers in destination countries and, if necessary, by the foreign employees, should be considered. A credit model developed in these pilot projects allowed to refinance a part of the preparation costs via a proportional back-payment of future wages. Legal issues of labour equal treatment need to be discussed carefully.
3. **Return costs:** An additional component that should be kept in mind, especially in a long-term, circular migration perspective, concerns the costs associated with future programmes to assist temporary and circular migrants within a framework aimed at promoting development in source countries (McLoughlin and Münz 2011).

e. Gender

1. **LTC and gender**: The gender aspects of policies in this area are particularly relevant, given the overwhelming majority of women employed in the LTC sector. Specific interventions are needed to ensure equal opportunities in implementing policies for migration in LTC, in light of the multiple risks of underpaid and irregular employment, as well as of exploitation and abuse (e.g. lack of appropriate health care, linguistic and social exclusion) associated with it.
2. **The "value" of LTC in society**: This issue concerns not only migrants, but the whole population, and refers to the cultural value and the prestige attached to LTC tasks in our societies. However, in the case of migration it overlaps with other dimensions, thus often having the effect of exacerbating existing inequalities (especially with those related to gender).

6. Conclusions

a. LTC labour shortages should be tackled via a **comprehensive strategy** that facilitates access to the LTC labour market via improved recruitment, recognition of qualifications, training and retention of LTC workers **at a national level.**

b. When such a strategy is not (yet) in place or has not yet produced the expected outcomes – as in the case of current shortages of LTC workers in Germany and other EU countries – the international recruitment of such staff in a sustainable

[14] An example in this respect is provided by the TaPiG-Project for Tunisian care workers in Hamburg (http://www.revesnetwork.eu/excellenceaward2013/file.php?zcid=135).

way requires **carefully considering the situation in potential source countries**, in order to prevent possible brain and care drain effects in source countries. Such a recruitment strategy should take into account **both short and long-term effects**.

c. While source countries with a younger **age structure** and high **unemployment rates** might be considered as "ideal" in this respect, those where care staff shortages co-exist with high unemployment, for example due to economic constraints, should be more carefully assessed, as permanent migration might exacerbate staff shortages, once the economy has recovered.

d. A stronger effort at the EU level is needed to reach a harmonised **recognition of qualifications in the LTC sector,** similarly to what already occurs with the Directive 2005/36/EC for health care workers. To this purpose, **pilot training programmes for LTC workers** might be jointly set up by different Member States, to test the feasibility of building a common professional qualification path.

e. More systematic EU-wide initiatives are urgently required **to regulate and monitor the role of transnational recruitment agencies**, in order to eliminate the abuse and trafficking of workers currently observed in some countries.

f. In summary, to create a sustainable "triple-win" situation, the recruitment of care staff should aim at: (a) reducing staff shortages in destination countries; (b) reducing unemployment in source countries; (c) improving the professional qualification of younger migrants; (d) facilitating and promoting circular migration between destination and source countries; (e) fighting the risk of accentuating already existing gender gaps in terms of equal opportunities and treatment.

7. Questions/issues for debate

The following topics are proposed for discussion by Member States representatives participating in the Peer Review, in order to tackle the issue at stake in a holistic way:

a. Given the individual right to free movement within the EU, the current situation of both high unemployment and care staff shortages in **some EU countries** also needs to be considered, as "free" migration from these areas might have a remarkable "drain" effect on their LTC system;

b. How to improve the mutual **recognition of professional LTC qualifications** and a closely related issue, the **promotion of LTC training**?

c. What should a **comprehensive LTC staff recruitment strategy** include, for example to prevent demographic impoverishment, "cultural clash" effects etc.?

d. In a medium-long term perspective, should the focus be on strategies to promote "**integration" in destination countries**, or rather on **return in source countries**? What are the socio-economic implications of the two options?

e. What would **funding mechanisms** of international care staff recruitment look like?

f. Which specific steps can be most effective in promoting **gender balanced opportunities** when implementing policies for migration in LTC?

Annex: National approaches in selected EU countries

Denmark

1. **Trends in LTC demand**: In Denmark older people (aged 65 and over) accounted for 15.9 per cent of the population in 2009 (Eurostat 2010a). Compared to many other EU member states, the dependency ratio is predicted to remain lower, at 41% in 2050 compared to 53% for EU-27 (Eurostat, n.d.). In relative terms, ageing may, therefore, not appear to be an imminent or sizeable problem. Nonetheless, by sheer numbers alone, the change is apparent: by 2040, the 65+ population will have increased by 400,000 (Danmarks Statistik 2006). As in many other countries, however, the health situation in Denmark is improving, and elderly people (67+) increasingly report that they find their health to be good (Kjøller and Rasmussen 2002). Today, an average 67-year-old also manages practical and mental tasks better than did an individual of the same age 25 years ago. Today, only three to five per cent of those aged 67+ need help with everything in their daily lives (Platz 2000). However, the number of people considered to be dependent (inability to perform one or more activities in daily living) is estimated to double, from 164,000 in 2007 to 327,000 by 2050 (Eurostat, 2010). Today, the number of formal care recipients is relatively high, as 21% of 65+ Danes receive home help (Rostgaard et al, 2011).
2. **Trends in LTC staff provision**: Although the real increase in the number of elderly is expected to be seen from 2050, there is already a shortage of care staff members in the LTC sector. The composition of LTC staff is at the same time problematic, since a large proportion are approaching retirement age: approximately every fourth staff member will retire within the next ten years, i.e. around 27,000 home helpers, care assistants and other care staff (Rostgaard et al, 2011).
3. **Legal framework:**
    - 3.1. **EU-countries**: Following the dispositions of art. 45 of the European Treaty, EU-citizens can freely move to Denmark for working purposes, including employment in the LTC sector, enjoying equal treatment with nationals with regard to labour market access and working conditions.
    - 3.2. **Non-EU (third) countries**: The present immigration situation in Denmark is strongly regulated and mainly work related, due to strict migration policies, thus being an example of a policy of zero migration (Rostgaard et al, 2011). Danish policies of awarding work permits are generally not geared to low-skilled labour, such as the LTC sector, but are instead intended to attract highly skilled labour. Apart from EU citizens and individuals with a residence permit, all others must obtain a working permit, which is given only if there is no one available among those currently residing in Denmark who can perform the specific job function. Denmark's immigration policy is similar to the United Kingdom's skilled immigration program, utilising a points based system called the Danish Green Card to attract skilled workers from outside the EU. In addition, Denmark has a work permit system called the Positive List scheme for people who have a valid job offer from a Danish employer. The Danish Green Card accrues points based upon criteria such as age, education, language skills, and work experience, and can grant a three year residence permit which allows living in Denmark and finding work. It is, however,

easier to obtain a residence and work permit for a sector with a shortage of manpower and, in particular, qualified labour, such as the elder care sector (jobs included in "The Positive List"), under the Job Card scheme. The Job Card scheme is normally granted for up to three years at a time, but is dependent on continuing work.

4. Policy options available to increase the supply of <u>domestic</u> LTC staff:

The challenge for the LTC system is, therefore, in the formal sector in order to ensure enough 'caring hands', which is the Danish term for the formal care staff involved in direct care provision, now and in the future.

Local governments have tried to motivate existing staff to increase their working hours with little success, as care workers already have a high rate of working hours (Hussein and Manthorpe 2005). The main strategy is therefore geared to the employment of first- and second-generation migrants already residing in the country (Rostgaard et al. 2011). Not only is there a demographic advantage as the migrant population is generally younger than the Danish population, and many are therefore about to commence higher education studies or begin a career in the LTC sector. In addition, working-age migrants are less active in the labour market and are reported to be 2.5 times more likely than Danes to be outside the labour market and not looking for work, a figure that is even higher for migrant women (Integrationsministeriet 2005). This recruitment strategy, therefore, mirrors the main integration policy, which is focused on the active inclusion of migrants within the labour market.

In addition, the Danish Government identified the improvement of working conditions within the care sector as an ongoing challenge, as poor working conditions are important predictors of early retirement and long duration of sickness leave, as well as raising the public profile of care workers through ad-hoc campaigns.

5. Policy options for the recruitment of migrant LTC workers:

5.a **From other EU-countries**: A few municipalities make use of the option to recruit skilled care labour abroad, for example from Germany and Sweden. Recently, initiatives aimed at attracting health care staff from Italy, have also been reported[15].

5.b **From non-EU countries:** presently, there is a lack of attention from the Government towards non-skilled migration, such as LTC-workers.

6. Gender aspects: The majority of LTC workers are women. The percentages of inactive women among those with a migration background in Denmark is higher than among other Danes. This makes this group the ideal target for interventions aimed at increasing participation into the LTC labour market.

[15]https://ec.europa.eu/eures/main.jsp?lang=it&catId=9590&myCatId=9590&parentId=20&acro=news&function=newsOnPortal

England

1. **Trends in LTC demand**: 8.6 million people in England are over 65 years old (2010) (Shutes and Chiatti, 2012). The latest projections estimate 13 million more elderly people in 20 years and approximately 22.3 million by 2060. Within this total, the number of very old people is growing even faster. In 2010, there were 10,670 centenarians in England.
2. **Trends in LTC staff provision**: In the formal LTC sector in England, the increasing employment of migrant staff has been concentrated among predominantly private sector providers such as residential and nursing care homes and home care agencies. Labour Force Survey (LFS) data for the UK show that between 2001 and 2009 the proportion of foreign-born care workers more than doubled from about 7% in 2001 to 18% in 2009, increasing from 13% to 23% among foreign-born nurses over the same period (Cangiano and Shutes, 2010). Significant regional variations exist, with foreign-born workers making up a much higher proportion of the workforce in the South East of England and, in particular, London (just over 60%) and a lower proportion elsewhere in the UK (Cangiano et al. 2009: 72). The growth of the foreign-born share of the care workforce occurred as a result of a rapid expansion of foreign-born care workers – from about 40 thousand to just under 130 thousand care assistants – and despite the increase in the number of UK-born workers in these jobs over the same period (Cangiano and Shute, 2010: 46). This increase largely comprised new arrivals to the UK: half of the current stock of foreign-born care assistants and nurses arrived since 2000. While the private sector has become, increasingly, the main employer of care workers overall, migrant workers are overrepresented within the private sector. Foreign nationals make up 19% of the workforce in the private sector, compared with 14% in the non-profit and 13% in the public sector (local authorities and the NHS) (Shutes and Chiatti, 2012). For particular care-related occupations, there is evidence of a much greater concentration of migrant workers within the private sector. Internationally recruited nurses[16] are estimated to make up a quarter of nurses employed in independent sector care homes[17] (25%) compared with 5% of nurses employed in the NHS (Ball and Pike 2007). Foreign-born care workers are also over-represented in the private sector compared with their UK-born counterparts: 79% of foreign-born care workers (who entered the UK since 1998) are employed by a private sector organisation compared with just above half of UK-born care workers (Cangiano et al. 2009: 74). The over-representation of migrant workers in the private sector is reflected in levels of pay. The LFS data suggest that foreign-born care workers (who entered the UK since 1998) are over-represented at the lower end of the pay scale compared with their UK-born counterparts: 42% earn less than £6 per hour (before taxes) compared with 31% of UK-born care workers (Cangiano et al. 2009: 82)[18]. It is estimated that the care labour force will have to expand considerably in the future to meet growing demand: in the UK, the workforce caring for older people will need to increase by 79% between 2007 and 2032 (Wittenberg et al. 2010: 15). In addition, the shift towards the use of cash-for-care payments,

[16] Nurses who qualified and were recruited overseas and started work in the UK between 1999 and 2005.
[17] The data do not distinguish between private and non-profit providers within the 'independent sector'. As indicated previously, over two-thirds of care homes in England are in the private sector.
[18] The National Minimum Wage in the UK between October 2008 and September 2009 was £5.73.

including 'direct payments'[19] and 'personal budgets', has similarly led to a growth in the percentage of people working in direct care jobs who are employed by recipients of direct payments (14% are employed by recipients of direct payments (Shutes and Chiatti, 2012)). Older people who are paying for their care through other sources of funding, including those who are privately funding their care, are also directly employing their care worker(s), though there is currently limited data on this group of employers and care workers (Eborall et al. 2010). The privatisation of the purchasing of care in England, particularly with regard to the increasing reliance of older people on at least partly if not entirely privately funding their care, may bring about an increase in the number of care workers directly employed by older people and their families.

3. Legal framework:

3.1. EU-countries: Following the dispositions of art. 45 of the European Treaty, EU-citizens can freely move to England for working purposes (including employment in the LTC sector), enjoying equal treatment with nationals regarding labour market access and working conditions. The enlargement of the EU in 2004 and a range of other types of visas have allowed the employment of migrants in the UK. Following EU enlargement, an increased number of EEA nationals from the A8 countries (mainly Poland) entered care work, though registrations of care assistants have since been in decline (Cangiano et al. 2009: 61).

3.2. Non-EU (third) countries: Policy towards labour migration in the UK over the past decade has been relatively liberal towards skilled and highly skilled workers, and restrictive towards workers in low-wage jobs (Ruhs and Anderson 2010). Prior to the introduction of the points-based immigration system in 2008, work permits could be obtained for occupations in health and social care that were conceived as 'skilled' according to national qualifications criteria, including nurses and senior care workers. Work permits data for health and medical services show an increase in work permits issued, including those for nurses and senior care workers, from 1,774 in 1995 to 26,568 in 2004, (Salt 2007: table 5.2). However, restrictions on recruitment to the NHS that were implemented since the mid 2000s made entry to the public sector much more limited for non-EEA workers, reflected in subsequent reforms to the admission of overseas nurses to adaptation programmes (Bach 2007) and in the decline in the issuing of work permits. These changes, therefore, restricted opportunities for employment for work permit holders to the private sector. At the same time, changes in the criteria for issuing and renewing work permits for senior care workers in the period prior to and since the introduction of the points-based system increased the uncertainty of the status of work permit holders, in terms of the duration and the possibility of renewal of temporary work permits. This form of 'institutionalised uncertainty' (Anderson 2010) was reinforced as legislation on obtaining permanent residency and citizenship in the UK likewise became increasingly restrictive during this period, including criteria on length of stay. Indeed, non-EEA migrant workers make up over two-thirds (74%) of foreign nationals compared with EEA nationals (26% in 2011), with the main nationalities

[19] There has been a rapid increase in older people receiving direct payments (from 537 in England in Sep 2001 to 20,610 in March 2008) (Eborall et al.,2010), though the numbers still remain relatively low as a proportion of older people receiving publicly subsidised provision.

comprising the Philippines, India, Nigeria, Zimbabwe and South Africa. NMDS-SC data for 2011: Work permit holders are likely to make up a significant share of this group. Foreign nationals continue to make up a higher proportion of workers among nurses and senior care workers (40% and 19% respectively) compared with other care occupations (NMDS). However, a number of other categories of non-EEA nationals, including domestic workers, students, working holidaymakers from former Commonwealth countries, asylum seekers and those coming to the UK through family reunion have also entered care work in the UK, both in residential and home care services as well as workers employed in private households (Cangiano et al. 2009)

4. **Policy options available to increase the supply of <u>domestic</u> LTC staff:**

Cangiano et al. (2009) identified several options to increase the supply of domestic LTC staff, i.e. people who are currently unemployed, inactive or employed in other sectors. These included increasing the funding and status of care work and fostering the public recognition of the invaluable contribution of care workers. These measures could also contribute to reduce turnover, which in social care jobs is very high, much higher than in most other occupations. These difficulties affect the private sector to a greater extent (Eborall et al. 2010: 102). So far, the propensity to apply for a direct care job among domestic staff has been relatively higher only among family carers and unemployed individuals, reflecting the very low wages in the sector and the lack of other suitable opportunities. This suggests that constraints other than freedom of choice are attracting the labour force in the LTC sector. Regarding the possibility to increase salaries, difficulties arise the from employer's side, since these labour-intensive industries may be reluctant to increase wages fearing a loss of competitiveness. In this sector, moreover, increasing salaries would result in a higher tax burden for citizens.

5. **Policy options for the recruitment of migrant LTC workers**:

Several policy options could be adopted to increase the recruitment of migrant LTC workers. These include (Cangiano et al. 2009):

- retaining a migration entry channel for senior care workers;
- monitoring the long-term need for a migration entry channel for lesser skilled care workers;
- improving Government coordination and communication with employers;
- promoting integration and access to long term residence and citizenship;
- ensuring access to language and skills training and guidance on cultural norms;
- addressing the issues related to migrant care staff at the organisational level;
- addressing the prevalence of discrimination and harassment.

6. **Gender aspects:**

As is the case of the UK-born care workforce, the majority of these workers are women (who represent 76% of the total, compared to 87% of UK-born care assistants, according to LFS estimates) (Eborall et al 2010).

Germany[20]

1. **Trends in LTC demand**: The demand for LTC services in Germany is expected to continue to grow in the next few decades. Recent projections estimate that by 2030 the over 65-year old population will grow by almost one third, reaching a total of 22.3 million; in the same period, the number of Germans in need of LTC is expected to increase from 2.4 to 3.4 million.
2. **Trends in LTC staff provision**: The ageing of the overall population is also affecting its workforce, as the number of Germans of working age is expected to decrease overall by 7.5 million, reaching a total of 42.2 million by 2030. As far as the LTC **formal** care sector is concerned, the number of LTC staff units hired by German care provider organisations, from 2000-2010, increased by 30% for residential care and by 50% for home care. However, in the last few years the situation has dramatically worsened. In 2008 the number of unemployed staff units (almost 10,000) exceeded the number of job vacancies in the LTC sector (just above 7,000), while in 2012 it had dropped to about 3,000 unemployed units compared to around 10.000 open positions. In light of the aforementioned projected decline in the overall workforce in the near future, it is therefore very unlikely that the 38% increase (i.e. +240,000) in the demand for additional LTC staff units between 2010 and 2030 will be met under the current labour market conditions. Regarding the **informal** care sector, it has been estimated that the number of private households directly employing migrant domestic/care workers approximately 200,000 families. In many cases this still takes place illegally, despite a special regulation to facilitate the procurement of such staff, albeit initially only for up to three years, which was introduced in 2002 (Bednàrik et al. 2013).
3. **Legal framework:** the legislative framework characterising the employment of LTC staff in Germany can be distinguished according to two main groups of countries of origin:

   3.a. **EU-countries**: Following the dispositions of art. 45 of the European Treaty, EU-citizens can freely move to Germany for working purposes (including employment in the LTC sector), enjoying equal treatment with nationals with regard to labour market access and working conditions. This applies from May 1st 2011 including countries that joined the EU from Eastern and Central Europe. Temporary restrictions still concern workers from Bulgaria and Romania until the end of 2013 (albeit these restrictions are currently limited to the need of obtaining a working permit for most – but not all - professions, and to the provision of cross-border services through posted workers http://ec.europa.eu/social/main.jsp?catId=508&langId=en), as well as workers from Croatia (except for seasonal workers and those with a university degree) in the first two years of EU-membership (i.e. until 30th June 2015) (https://ec.europa.eu/eures/main.jsp?acro=free&lang=en&countryId=DE&fromCountryId=HR&accessing=0&content=1&restrictions=1&step=2). The latter country, however, could count on a specific bilateral agreement for nursing care staff already present before it joined the EU, allowing Croatian citizens to work in Germany in the LTC sector if they possess a qualification as an elder care nurse (BMWi 2012:39). In light of this situation, it can be concluded that de facto almost all EU-citizens can work as LTC staff in Germany.

[20] If not otherwise stated, the source of the information summarised in this section is BMWi 2012.

3.b. **Non-EU (third) countries**: To work as LTC workers in Germany, non-EU nationals need a working permit issued by the German national employment agency based on a bilateral agreement with the employment agency of the sending country. Currently no country (except in the case of Croatia mentioned above) has such an agreement. Therefore, specific recruitment campaigns, and related legislative measures, would be preliminarily required to allow third-country nationals to work as LTC-staff in Germany. Similar restrictions also apply to access procedures to the German LTC training system.

4. **Policy options available to increase the supply of domestic LTC staff**: a series of different strategies have been recently analysed by the German government at the federal and/or the Länder level to improve existing opportunities to involve a larger segment of the domestic workforce in the LTC sector. Among them, a relevant role might be played by measures to increase:

   4.a. the number of full-time workers (currently reaching only 33% of those employed in residential care and 25% of those in home care);

   4.b. the female employment rate (which is still far from reaching that of German men);

   4.c. the attractiveness of the LTC sector via:

      i) improved (re-)training opportunities (as re-trained staff represents over 60% of elder care nurses), through a better funding of qualification paths and higher numbers of students allowed to access them;

      ii) improved career opportunities;

      iii) improved networking of LTC staff at the regional level and counselling opportunities;

      iv) higher wage levels;

      v) better coordination and integration of LTC staff position with the health care system.

   The simulation of different scenarios based on assumptions considering all these dimensions – including the potential effects of current reform proposals in the field of LTC training in Germany and of the EU Directive 2005/36/EG on the recognition of professional qualifications - seems however to suggest that, on the whole, the expected increase in the demand for LTC staff will hardly be covered through the German domestic workforce in the years to come.

5. **Policy options for the recruitment of migrant LTC workers**: in light of the current and expected staff shortages in the LTC sector, the German government has started analysing the possibility of recruiting foreign care staff. This analysis has tried to consider and weigh the pros and cons from the perspective of both the country of origin and of destination, as well as from that of the individual migrant.

   5.a. **From other EU-countries**: As a first step, data have been collected on wage differentials between Germany, France and the UK (as "competing" destination countries), on the one hand, and some Eastern and Southern European countries (as potential countries of origin), on the other hand. A similar exercise has been carried out to estimate country-differentials in terms of unemployment risk and of demography-driven care workforce demand, as well as to assess the role played by other potentially relevant factors such as care qualification and language skills. The main outcome emerging from these analyses is that the possibility of recruiting foreign LTC

workers within the EU-boundaries seems to be quite limited, because many of the potential sending countries are facing or are going to face a domestic LTC staff shortage.

5.b. **From non-EU countries:** The analysis of the recruitment possibilities concerning LTC from third (non-EU) countries, with a particular focus on some Asian nations (India, Vietnam, the Philippines, Korea and China), seems to suggest that at least for some of these sending countries, especially India and the Philippines, the positive opportunities, in terms of remittances and knowledge transfer, might prevail over the migration-related costs and disadvantages. A recent analysis of the experience gained in the early 90s with the programme "German Green Cards for Information Technology (IT) professionals" (http://www.germangreencards.com/index_details.html) where working permits were issued only for a limited number of years and therefore obliged the migrants to return home once they expired, shows that, in order to be effective for the LTC sector, a similar programme would have to offer a much longer perspective and even long-term opportunities of full integration in German society (BMWi 2012:39).

In the short term, two concrete measures could be represented, in the first place, by the *inclusion of LTC jobs in the list of so-called "staff shortage professions"*, which allows facilitated access conditions to the German labour market for skilled workers and, secondly, by the design and implementation of scientifically supervised, publicly funded *pilot projects for the managed migration of skilled LTC workers* aimed at developing a comprehensive framework for the professional, linguistic and cultural preparation, monitoring, return and knowledge-transfer of LTC staff from selected non-EU countries.

6. **Gender aspects:** The general female employment rate (i.e. for the whole labour market) has been increasing remarkably in Germany the last few years, and is 67.7% today, i.e. almost 9 points higher than the EU-average (http://epp.eurostat.ec.europa.eu/statistics_explained/index.php?title=File:Employment_rates_for_selected_population_groups,_2001-2011_(%25).png&filetimestamp=20121030183007), with the highest level (over 80%) within the 40-44 age group (BMSFSJ 2011). Women with higher educational levels show higher employment rates, while women with a foreign nationality are characterised by much lower rates (circa 20 points lower than those of German women). Not differently from other countries, the German LTC sector is traditionally a female "stronghold" - as women represent 86% of the whole national LTC workforce – displaying at the same time a very high rate of part-time workers (46% of women, compared to 9% of men for the whole workforce).

Italy

1. **Trends in LTC demand**: Italy is currently one of the most aged countries in the world, with over 20% of the population 65 years or older. In absolute terms, this means around 12.3 million older people, of which half (6.1 million) more than 75 years old. Estimation of demographic trends shows that the number of older people will constantly increase in the near future, reaching 16.6 million people in 2030, with 7.8 million people over 75 years of age (ISTAT 2013). Today dependent older people represent 14% of the older population (Chiatti et al. 2011). A conservative projection of future demand of LTC shows that the elderly in need of care will pass from the current 1.7 to 2.4 million in 2030. The "worst care scenario" would even suggest 3.5 million.
2. **Trends in LTC staff provision**: People of working age are expected to decrease significantly in the next few decades because of population ageing and low fertility rates. The age dependency ratio will increase from 29.4 to 62.3 in 2030. This means that there will be fewer people active in the labour market, reaching only 30 million in 2030 (-8.8 million since 2011) (Chiatti et al. 2011). In the case of LTC workers, the number of professionals employed by the formal sector is relatively low, due to the low level of coverage of Italian LTC in-kind services, with a very residual segment represented by migrants. The Italian LTC system mainly aims to maintain the dependent person at home thanks to informal care provided by families and to the private employment of care assistants – in most cases, migrants (Lamura et al. 2010). Considering both regular and parallel markets (the latter segment constituting around two thirds of the total), it is estimated that circa 830,000 migrants are employed in LTC at home (the portion of Italian workers is low), usually with no formal qualification in care and nursing (Pasquinelli and Rusmini eds. 2013). The first sending country is Romania (covering around one fourth of the overall migrant LTC workforce), whereas all the other major nationalities are extra-EU (including Ukraine, Philippines, Moldova, Peru), except for people coming from Poland (just 4.3% of all foreign workers) (Fondazione Leone Moressa 2011). The number of migrant workers constantly increased during the last two decades (INPS, several years), and it is not likely to stop in the short- or even in the long-term, since the LTC demand will increase in the future. In addition, the discrepancy between the number of professionals in the formal sector and the phenomenon of migrants caring for elderly living in the community cannot be easily solved. Furthermore, the constant increase of female participation in the labour market will affect the availability of family carers and push the need for hiring care assistants (Lamura et al. 2010a).
3. **Legal framework**: Legislation concerning migrant LTC workers should be distinguished according to their country of origin:

   3.a. **EU-countries:** In compliance with agreements made at European level, all EU citizens can move and work in Italy with equal opportunities of national workers. Employers can directly hire migrants without restrictions. After Romania and Bulgaria joined the EU in 2007, people from these countries still had to complete an additional bureaucratic procedure in order to receive a work permit. This transition period ended on December 31st, 2009, therefore the procedure is no longer necessary.

   3.b. **Non-EU (third) countries:** People from non-EU countries need both a visa and a stay permit to work. If the migrant is still in his/her country of origin, the Italian employer should apply to the local immigration office for a working permit for the person, who can then enter Italy and apply for a stay permit for work to the local police headquarters. However, the possibility to

apply in this case depends on the annual "Fluxes Decree" (last one: DPCM 15th February 2013) which sets both a maximum number of non-EU nationals to be hired and the specific sectors and requirements of open positions. For many LTC workers from non-EU countries, the common solution is to enter Italy with a regular visa and then to find a job while in Italy, thanks to eventual informal networks (e.g. relatives, friends or ethnic groups already present in Italy). However, an undetermined number of LTC workers is able to enter Italy even without a visa or a stay permit, or to continue to stay even after visas and permits expire. Since March 10th, 2012, in addition to ordinary documents needed to apply for a regular stay permit, the migrant worker who enters Italy for the first time has to sign an "Integration Agreement" with the State (DPR 179/2011). The latter commits itself to provide equal civil rights, as well as to sustain the integration process of the migrant worker through the provision of information and training sessions on different issues, including language, culture and organisation of public institutions. The migrant has to attend these sessions and to complete all duties concerning enrolment of children in Italian schools and contributions to the social security system (www.inps.it/portale/default.aspx?sID=%3b0%3b6969%3b6974%3b6982%3b6983%3b6989%3b&lastMenu=6989&iMenu=1&p4=2). Since September 2013 (Law 97/2013), non-EU citizens with an EU stay permit of at least 5 years can access permanent working positions in Italian public organisations (except for those directly concerned with the defence of national interests, for example the judiciary or the armed forces). This would imply, for instance, that non-EU migrants employed on a temporary basis in the LTC sector might now be hired with a permanent contract.

4. **Policy options available to increase the supply of domestic LTC staff**: The Italian LTC system has been relying for a long time on a cash-for-care scheme, which favours the provision of allowances instead of in-kind services. Home care coverage is delivered to 5.6% of people over 65 years of age (with a very low yearly intensity of 20 hours per user) (Barbabella et al. 2013), whereas institutional care is offered to just 1.8% of the elderly (ISTAT 2013). A consequence is that formal staff dedicated to LTC services is low. OECD data for 2003, the latest for Italy, states that 23,000 nurses were employed, whereas France had greater than twice that amount (58,000) and Germany had more than six times the number of nurses (146,000) (OECD 2012). Despite no major explicit policy has been adopted nor discussed at national level to increase domestic LTC staff in the formal sector, recent data show an increase in the number of new nurses (+45% between 2007 and 2012). This is due to an increased presence of male and younger nurses, while foreign nurses have dropped from 35% to 15% (who however today achieve their degree in Italy in 50% of cases, compared to 30% in 2007) (IPASVI 2013). Concerning LTC staff privately hired by care recipients and their families, it is estimated that less than 20% are national workers (Fondazione Leone Moressa 2011). Also in this case there are few paid carers. The reason is that in most cases a primary family carer exists, who takes care of the older person without any remuneration. Governments have not yet designed any programme to increase the availability of national LTC workers or their competences, even if experts and policy analysts have been discussing the need to address three important issues (AGENAS 2012; NNA, ed. 2009; Gori, ed. 2010): 1) the training of LTC workers and family carers to improve caregiving skills and the quality of care provided; 2) a better integration of LTC workers and family carers in the network of formal services; 3) to obligate beneficiaries of allowances to spend the money for care needs (at the moment, allowances can be used without any constraint).

5. **Current policy options for the recruitment of migrant LTC workers**: The low coverage of public LTC services and the generous application of a cash-for-care scheme based on the provision of allowances to dependent people (assigned to 12.5% of people over 65 years of age), constitute the main drivers of the migrant LTC workforce phenomenon in Italy (Barbabella et al. 2013). It is clear that the current LTC system is sustained by the employment of migrant workers by households, with payments out-of-pocket. Considering only official statistics, non-EU nationals constituted 47.6% of the total in 2012. However, this percentage decreased significantly in last few years (-8.8% since 2010) (Ministero del Lavoro e delle Politiche Sociali 2013). Concerning EU-nationals, Romanians, and to a minor extent, Polish workers, are the major representatives. However, no specific policy addressing them was put in place. Generally speaking, fiscal incentives are available for care recipients and families employing LTC workers in home care with regular contracts (Law 342/2000 and Law 296/2006). On the other hand, the main policy option adopted to address the issue of non-EU nationals concerned the legalisation of those people employed in the parallel market without a regular contract or even a stay permit. Some ad-hoc decrees allowed migrants and their employers to make their position regular without legal consequences. In 2002, 350,000 domestic workers, including LTC workers, were legalised, and in 2009 about 294,000. More generally, the government sets annual quotas for migrant workers from non-EU countries. Applications usually exceed available positions. However, in the last few years there was a significant decrease of available positions, mainly due to the recent financial crisis affecting the Italian economy and impacting negatively on unemployment (even of immigrants): from 65,000 positions in 2007 to 14,000 in 2012 and 30,000 in 2013.
6. **Gender aspects:** Generally speaking, Italy failed to reach the goal of female employment rate set by the Lisbon Strategy set at 60% and it is not in line with the goal of Strategy Europe 2020 (75%). In fact, employment rate of women is still low, compared to the European average and other countries: 46.9% in 2011 (ISFOL 2012). The percentage has been stable in the last few years, an indicator that the economic crisis has constituted a strong barrier for entering the labour market. Women are usually paid less than men – a mean of 77% of male salaries. In the formal sector, the presence of women is high. Over 87% of staff in LTC institutions are constituted by women (Fujisawa and Colombo 2009), whereas female nurses constitute around 77% of the total nursing workforce in the health care sector (Ministero della Salute 2012). Among care assistants privately employed by households, over 80% of non-EU LTC workers are female (Ministero del Lavoro e delle Politiche Sociali 2013).

Romania

1. **Trends in LTC demand**: The proportion of Romanians older than 65 years of age is 15% and those older than 80 are 3.3%. Life expectancy at birth is 77.5 years for women and 70.1 years for men (INS 2011). In the EU, life expectancy at birth 83.2 years for women is and 77.4 years for men. Although Romania is one of the European countries with the youngest population, the demand for all types of social services for the elderly has grown continuously in the past few years following trends in population ageing and increased life expectancy. The need for care services throughout the country in 2008 was evidenced by the large number of people waiting to access elderly homes (Popa 2010).
2. **Trends in LTC staff provision**: The available settings for LTC in Romania include home care, nursing home care and residential care. Currently, Romania has a major shortage of institutionalised services. Home care is the most commonly used option for dependent older people because of the comfort the family provides and the reduced costs compared to institutionalised care. This, however, raises many problems. Most family caregivers are women (the wives or daughters of the care-recipients) and many of them are elderly themselves, with the probability of becoming dependent. Family care is more common in rural areas, where traditions and moral values are maintained to a greater extent (Ministerul Muncii 2008).

   This framework is not sustainable in the long run, not only because of ageing of the Romanian population , but also due to the high emigration rate. Data from the latest Census confirm a decrease of the overall population of over 3 million inhabitants, 77.5% of which is due to external migration. In terms of characteristics of those who emigrate from Romania to elsewhere in the EU, for a period longer than 12 months, most of them are young, between 25 and 45 years old, with men and women in roughly equal numbers, concentrated in a relatively small number of sectors: construction work, accommodation and catering and private household work, such as care and cleaning (Rolfe et al. 2013).

   2.a. **Emigration:** Following this trend, Romania is also confronted with an accentuated migration of medical personnel from the health care sector, in particular determined by the large difference between Romanian salaries and that of host countries, especially Italy. The massive migration of medical staff from the Romanian health care system affects the quality of health care (Rotilă and Celmare 2007). This trend was confirmed by a 2011 study addressed to medical staff. Respondents declared to be unsatisfied with their job, mainly because of the low salary (63.7% of subjects declared an income below 1,500 RON, i.e. 336€ c.a), followed by poor work conditions. Overall 73% of respondents considered emigration. Medical staff opt for a job with higher remuneration in a foreign country for many reasons: confronting problems induced by failure of the system, lack of job satisfaction and motivation as consequences of fact that the medical profession does not have social status commensurate with their contribution to society (Rotilă 2011).

   2.b. **Immigration:** Romania, though not a popular destination for immigrants, has recently experienced a growing wave of immigration, mostly from Moldova, Turkey and China, as well as from Africa, the Middle East, and the former Soviet Union. In 2005, there were 133,000 immigrants living in Romania (UN 2006). From 2007 there has been an increase in immigration for work according to the number of work permits issued by the Romanian Office for Immigration. This has been followed by a sharp decrease with the

onset of the economic contraction throughout the period of economic and financial crisis from 2009-2010. As of September 30th 2010, there were registered 59,358 legally registered foreigners (Alexe and Păunescu 2011). In any case this new wave of immigrants who chose Romania as a country of destination is unlikely to covering the shortage of skilled personnel in the LTC system.

3. **Legal framework:**

   3.a. **Immigration:** Regarding immigration from EU member states, Romania follows the dispositions of art. 45 of the European Treaty. EU-citizens can freely move for working purposes enjoying equal treatment with nationals with regard to labour market access and working conditions. In any case, the three most represented countries of origin are non-EU members (i.e. the Republic of Moldova, Turkey and China). Romania sought and obtained a special mobility partnership between the EU and the Republic of Moldova in order to diminish migration from this country. This partnership remains to be implemented (Rohova 2011).

   3.b. **Emigration:** The main destination countries for Romanian migrants are Spain and Italy and, to a lesser extent, Germany. These choices reflect employment opportunities and similarities in language, as well as restrictions and freedoms on the right of Romanians to work across the EU. While Spain initially had no constraints, in July 2011 it introduced restrictions for Romanian workers until the end of 2013, while Italy lifted restrictions in January 2012. As time goes on, the presence of social and economic networks of existing migrants may mean that Romanian migrants continue to migrate to Spain and Italy rather than to other EU member states (Rolfe et al. 2013).

4. **Policy options available to increase the supply of domestic LTC staff:** The high costs for institutionalised care, the shortage of medical staff, the emigration of an active population all contribute to the unmet demand and supply of LTC skilled workers. The Romanian government is implementing different actions to tackle these challenges.

   4.a. **Pilot project to increase salaries of physicians in the public sector:** This project is going to start on January 1st 2014 with an initial duration of 6 months(Ministerul Sănătății 2013). During this period, results will be evaluated monthly in order to decide whether to prolong the project. The salary increase will occur through two main paths: economic incentives according to performance indicators and the possibility to provide private medical services in the public health unit after working hours. The aim of this project is to boost performance and competitiveness, by excluding medical profession from the public sector.

   4.b. **NGOs:** An attempt to meet the demand for LTC is given by NGOs, which have become very involved in recent years and are now the second biggest provider of services for the elderly, after the public services. The current tendency in Romania is to shift elderly care away from institutional care to home care or assisted living because it allows them to maintain their independence and social networks and decreases governmental expenditure on LTC (Popa 2010).

5. **Current policy options for the recruitment of migrant LTC workers**: in the case of Romania it is more correct to speak of "return migration". Regarding migrants in the health sector, the growing amplitude of nurses' emigration (greater than for physicians) may have a serious impact on health-care delivery

in the future. Thus, monitoring and controlling the migration of nurses through a valid information system is vital. One step in this direction has been through the Government Decree 187/2008, which enforces the plan of action on the return of Romanian migrant workers, consisting in: establishing, maintaining, and updating databases periodically; carrying out an information campaign on the job opportunities in Romania; elaborating a system to stimulate the return and professional reintegration of Romanian migrant workers (IOM 2008).

In addition to this, Romania also carried out steps to encourage immigration by highly skilled workers, as well as developing policies to face labour shortages. One of these was simplifying the work permit scheme with a new residence permit for work purposes, replacing two separate permits, i.e. work authorisation and working visa/residence permit (OECD 2008).

Finally, Romania organised bilateral agreements with several countries. This is the case for instance in Italy, where some local authorities have signed protocols with Romanian authorities to train and recruit nurses (e.g. Parma with that of Cluj-Napoca or Veneto with Timiş County) (Dumont and Zurn 2007).

6. **Gender aspects:** The vast majority of Romanian emigrants engaged in LTC, in institutionalised settings or privately employed by families, are women. Regarding skilled workers, those with the highest probability of being employed in the LTC are nurses. There are no official data on the number of nurses who have migrated to other countries or changed jobs, although the Romanian Ministry of Health reported that from January 1st 2007 to December 31st 2008, 4,608 nurses and midwives (3.8% of total) have requested mutual recognition of certificates for their diplomas in the EU and 3,525 have received it (Vlădescu and Oslavsky 2009).

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