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Filling the gap in long-term professional care through systematic migration policies

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Filling the gap in long-term professional care through systematic migration policies

Giovanni Lamura, Carlos Chiatti, Francesco Barbabella and Mirko Di Rosa
National Institute of Health & Science on Ageing (INRCA), Italy

Synthesis Report

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Executive Summary

This report summarises the main contents of the Peer Review on the role of migration policies to tackle staff shortages experienced in the long-term care (LTC) sector by EU Member States. It provides an overview of the issues analysed in the introductory discussion paper and discussed in a meeting held on 23-24 October 2013 in Berlin.

Part A of this report focuses on the **policy context at European level**. It begins by underlining the need for a comprehensive conceptual framework, to achieve integrated strategies considering: the policy areas of migration, LTC and labour market; the perspectives of both source and destination countries; and the macro-societal, meso-organisational and micro-individual level. It analyses the legal distinction between EU and non-EU workers, and the legal measures available to recruit LTC workers from non-EU third countries (e.g. Blue Card and EU Mobility Partnerships), and the contribution of other EU initiatives undertaken in this field, such as the "Working Group on Age", the "Joint Action on Health Workforce Planning" initiated within the "Action Plan for the EU Health Workforce", the undergoing reform of the EURES "Job Mobility Portal" and the Social Investment Package (SIP). Finally, it recalls the main principles stated by the WHO "Global Code of Practice on international recruitment of health personnel".

Part B outlines **the host country's (Germany) policy** in this area, providing first some basic information on ongoing demographic and labour market trends. After an overview of essential political, cultural, ethical and linguistic aspects to be considered in the recruitment of LTC staff in the country, it examines the role of recruitment and other related costs before, closing with a summary of the main prevailing political perspectives.

A synopsis of the main **policies and experiences in the countries involved in the Peer Review** constitutes the focus of section C. Here common trends and distinct approaches are illustrated, using the same analytical structure, including issues such as: the existence of LTC staff shortages; strategies used to avoid difficulties in providing elder care in countries from which migrants come; improving the mutual recognition of LTC qualifications; promoting "integration" in destination countries or return to countries of origin and balancing gender opportunities.

The core **issues discussed during the meeting** are reported in Part D. These include, first, a common concern with the low prestige and status of LTC work and with the need to adopt a comprehensive LTC staff recruitment strategy based on the WHO "Global Code of Practice". Participants also dealt with strategies to reduce the mismatch between migrant care workers' expectations and the "real" situation they experience in destination countries. Gender issues, funding mechanisms, pros and cons of circular, temporary and permanent migration and of new policy options – e.g. the "global training partnerships" suggested by the World Bank – are the additional topics discussed at the meeting.

The **main lessons** emerging from the Peer Review process (Part E) suggest that, in the long-term, priority should be given to providing LTC via the domestic workforce. In the case of temporary staff shortages, the WHO's Code of Practice represents a crucial – albeit improvable – reference, to be taken into account when modelling LTC demand-supply conceptual frameworks, to systematically include the perspective of countries of origin.

Participants reflected also on possible horizontal and/or vertical staff substitution strategies – which need, however, a more precise categorisation of specific LTC tasks and professions – and on the role of training and education in reducing the negative impact of LTC migration. After a series of considerations specifically addressing the German case, the final section highlights how this Peer Review contributes to the Europe 2020 strategy (Part F).

A. Policy context at European level

The issue of whether and how migration should play a role in filling possible staff shortages in long-term care (LTC) provision is a complex one, requiring a comprehensive conceptual framework to develop policy interventions that are respectful of all parties involved[1]. Governing migrant work in the LTC sector implies, first of all, a parallel intervention in at least three different policy areas: migration, LTC and the labour market. Secondly, it involves being able to estimate the impact of different policy options for both source and destination countries. And, finally, it should aim at identifying opportunities and challenges at macro level (i.e. global, European or national), meso level (i.e. company, organisation or social network) and micro (individual) level.

While internationally two main approaches can be distinguished – active or managed (i.e. attempting to control migration flows) and passive or unmanaged (i.e. trying to adapt to them) – the EU policy is based strictly on the **legal distinction between EU and non-EU** (or "third country") **migration flows**, especially with regard to access to the labour market and recognition of professional qualifications. As regards the first category, the freedom of movement of EU workers is a fundamental policy chapter of the EU *acquis*, regulated by Article 45 of the Treaty on the functioning of the European Union, so that no special work permit is necessary for workers from another EU Member State, who in principle can also count on reciprocal recognition of professional qualifications[2]. The access of workers from non-EU third countries (i.e. outside the European Economic Area – EEA – or non-party to bilateral agreements) to individual EU country labour markets is subject instead to a national scrutiny reserve (i.e. the host country retains the right to check whether national workers are available prior to granting foreign personnel a work permit for the domestic labour market).

In addition, **national recruitment policies** are possible, within the legal framework set up by the following EU-level initiatives, which all underscore the importance of ethical recruitment, especially when it concerns sectors that are particularly vulnerable to risk of brain drain, such as the LTC sector:

- **Blue Card Directive** (2009/50/EC) (http://apply.eu/): this measure is aimed at attracting highly qualified migrants 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". Adopted in May 2009, the EU Blue Card is demand-driven and based on a renewable work contract with a validity of between one and four years;
- **Single Permit Directive** (2011/98/EU): this was adopted in December 2011 to create a set of rights for non-EU workers legally residing in an EU country. 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

[1] For a more in-depth analysis of the issues reported in this synthesis report please see the discussion paper by Lamura et al. (2013) http://ec.europa.eu/social/BlobServlet?docId=11116&langId=en

[2] The only exceptions remaining are the transitory restrictions imposed in some countries for citizens from Croatia (potentially until 2020), as this country joined the EU only in 2013 and other MSs can apply these limitations for a transition period.

conditions, education, vocational training, recognition of diplomas, social security, tax benefits, access to goods/services and housing), so enabling them to move from one occupation to another according to the demand for labour, including to LTC jobs;

- **EU mobility partnerships**: these are bilateral agreements providing a concrete framework for dialogue and cooperation between EU Member States and non-EU countries, in three main areas: legal migration; migration and development; and the fight against irregular migration (the weight of each element depending on the needs of the countries involved). The priorities for each mobility partnership are set via joint political declarations (signed by the EU, interested EU Member States and partner countries), which can include specific project initiatives and concrete actions. As they are not legally binding, they are an open, flexible measure that can be adapted and tailor-made to the needs of the partner countries, also including, in principle, visa facilitation and readmission agreements. Healthcare workers can be the subject of such partnerships, as in the case of the mobility partnership signed in 2008 between Moldova, EU and several EU Member States[3]. Among its main contents were a labour mobility agreement with Italy, a set of measures to facilitate assisted and voluntary return migration and to address the negative effects of migration on minors and families left behind, and the implementation of the EU Moldova Visa Facilitation and Readmission programme.

The policy measures indicated above need to be analysed in the wider framework of **Europe 2020**, the overarching EU strategy which is aimed at creating the conditions for a smarter, more sustainable and inclusive pattern of growth (European Commission 2010). Within Europe 2020, five key targets are to be achieved by the end of the decade in respect of education, research and innovation, social inclusion and poverty reduction, climate change and energy and employment. In the last area, in particular, the EU aim is to **reach an employment rate of 75% for those aged 20-64**. To tackle the economic and social challenges of high unemployment and demographic change, the EC has, moreover, launched an **Employment Package** (European Commission 2012a, 2012b, 2012c), setting out key measures to support job creation, restore the dynamics of the labour market, enhance EU governance and accelerate the portability of pension rights. The healthcare sector is identified specifically as one of the job-rich sectors whose potential needs to be harnessed.

Another flagship initiative of the Europe 2020 strategy is the **Agenda for New Skills and Jobs**, which presents a set of concrete actions for improving flexibility and security in the labour market ('flexicurity'), equipping people with the right job skills, enhancing the quality of jobs and ensuring better working conditions as well as improving the conditions for job creation. These measures are combined with a number of additional initiatives and programmes set up by the EU in the related areas of migration and LTC, among which the following play a major role:

1. The **Working Group on Age**, set up by the Social Protection Committee[4] (SPC WG AGE) is currently preparing a specific LTC report based on the Staff Working Document

[3] Bulgaria, Cyprus, Czech Republic, France, Greece, Germany, Hungary, Italy, Lithuania, Poland, Portugal, Romania, Slovenia, Slovakia and Sweden. The agreement is available at http://eeas.europa.eu/delegations/moldova/documents/eu_moldova/joint_declaration_2008_en.pdf

[4] The Social Protection Committee is an EU advisory policy committee, established by the "Treaty on the Functioning of the EU" (article 160), which: 1) monitors social conditions in the EU and the development of social protection policies in Member countries on social inclusion, health care,

drafted in 2013, to be delivered to the Social Protection Committee in early 2014. This report will analyse the main challenges ahead in the LTC sector, in terms of data collection, demographic trends, dependency profiles, financial trends and – what is relevant here – shortages of human resources. Under the motto "doing more (and better) with less resources", it will highlight how the EU can help to tackle these challenges, especially as regards strategies for promoting prevention and rehabilitation, raising the capacity for independent living and increasing the cost effectiveness of LTC provision by improving the use of existing resources (including human resources) and integrating ICT into the delivery chain.

2. The "**Action Plan for the EU Health Workforce**", adopted in 2012 by the European Commission as part of a broader range of measures undertaken as part of the *Towards a job rich recovery* Communication (COM(2012) 173 final) to encourage employment and economic growth in Europe (European Commission 2012). The Action Plan, to be implemented by the EC Directorate General for Health and Consumers (DG SANCO), is aimed at assisting Member States to tackle these challenges and sets out ways of fostering European cooperation and share examples of good practice in order to help improve the planning and forecasting of the workforce in the health sector, anticipate future skills needs and improve the recruitment and retention of health professionals, while mitigating the negative effects of migration on health systems through the implementation of ethical rules for international recruitment.

   As part of this Action Plan, a **Joint Action on Health Workforce Planning** (JAHWP) (http://euhwforce.weebly.com/) has been adopted with the objective of piloting a platform for collaboration and exchange between EU Member States. Launched in April 2013 and to be completed in 2016, the JAHWP involves all 28 EU Member States, under the coordination of the Belgian Ministry of Health. The main outcomes are expected to be to contribute to improving data collection and analysis as regards the mobility of the healthcare workforce through increasing the EU-wide capacity to estimate future needs in terms of skills and competences, by providing ad hoc guidelines and stimulating action through a consolidated network across EU Member States. Background information for this was collected by a comprehensive feasibility study published in 2012 (Matrix Insight 2012).

   Other relevant initiatives undertaken under the Action Plan for the EU Health Workforce include:

   - **two calls for tender** launched within the 2013 Health Programme run by the Executive Agency for Health and Consumers (EAHC) (http://ec.europa.eu/eahc/health/): one of them aimed at mapping and reviewing opportunities in the EU for "continuous professional development and lifelong learning for health professionals"), the other at identifying strategies for their "effective recruitment and retention";

long-term care and pensions under the social open method of coordination (OMC); and 2) promotes discussion and coordination of policy approaches among national governments and the Commission. It prepares Council discussions on social protection and on the country-specific recommendations in the context of the European Semester. It also produces reports and opinions on its own initiative or at the request of the Council or the Commission (http://ec.europa.eu/social/main.jsp?catId=758&langId=en)

- **a study on the feasibility of setting up a EU "sector skills council on nursing and care"**[5], with the goal of laying the foundations for a future EU Sector Council, by developing q consensus on the scope, activities and mandate of the Sector Council, and engaging with the relevant stakeholders (www.skillsfornursingandcare.eu);
- **a first pilot Sector Skills Alliance (SSA)**[6] **to promote a European training module in the field of elderly care:** the EFEC (ECVET7 For Elderly Care) SSA has been selected to carry out a series of activities in 2013-14 to improve comparability, transparency and mutual recognition of qualifications in six partner countries (Estonia, Finland, Germany, Italy, Lithuania and the UK) and to implement ECVET principles in elderly care work (www.ecvetforec.eu);
- **a workshop to review the qualifications and training of healthcare assistants** organised by the pilot network of nursing educators and regulators (www.hca-network.eu).

3. The **European Employment Services (EURES)**: Set up in 1993[8], EURES is a European network for worker mobility involving the EC and the Public Employment Services (PES) of the EEA countries and social partner organisations. It is responsible for managing exchange of information on the availability of labour, vacancies and living and work conditions and facilitates cooperation between its members and stakeholders, so contributing to the development of a European labour market, including cross-border commuting. The redesign of the EURES "Job Mobility Portal" (https://ec.europa.eu/eures/) is expected to improve the recruitment and placement platform at the European level, as indicated in the *Compact for Growth and Jobs* (European Council 2012), so fostering mobility of EU nationals as well as supporting the management of economic migration from non-EU third countries in the LTC sector. The new system will focus on employment results and improving cooperation between public and private employment services (via accreditation of the latter at national level to guarantee the same quality standards), in order to expand their capacity to support targeted mobility schemes at EU level (both those initiated and implemented at national level and those launched by the European Commission). This will create a more powerful adjustment mechanism to help correct labour and skills shortages which co-exist with high unemployment and to improve the allocation of resources and the competitiveness of the EU economy in line with Europe 2020 requirements.

5 Sector councils are platforms at sector level where stakeholders can gain an insight into the likely developments in employment and skills needs, in order to assist policy making in, or for, the sector.

6 A SSA is a new category of transnational partnership to promote cooperation between three categories of partner: vocational education and training providers; sector-specific expertise including social partners, sectoral federations, Chambers pf commerce, etc.; and public or private bodies and authorities involved in education and training (http://ec.europa.eu/education/calls/s0112_en.htm).

7 ECVET: European credit system for vocational education and training.

8 The current legal basis of EURES is derived from the Council Regulation (EEC) 1612/68 on freedom of movement of workers within the Community, now codified as Regulation 492/2011 of 5 April 2011, part II (mechanisms for vacancies clearance and exchange of applications), which already underwent a reform in 1992. It lays down the obligation for the MSs to exchange vacancies and applications for employment which have not been satisfied at national level. Commission Decision 2003/8/EC of 22 December 2002 implemented the above Council Regulation 1612/68 by defining the EURES network, objectives, composition and governance.

4. As part of the Joint Action on Health Workforce Planning mentioned above, a **workshop** is currently being organised **to share examples of best practice and to facilitate the implementation of the WHO *Global Code of Practice*** (see below for further details), while the European Commission Directorate-General for Development and Cooperation – EuropeAid – is funding a specific project on "**Health workers for all**", under Dutch coordination, which brings together 8 NGOs to raise awareness of the Code among policy-makers in the countries of origin of healthcare workers (www.healthworkers4all.eu/).
5. The **Social Investment Package (SIP)**: adopted in February 2013 by the EC through its *Communication on Social Investment for Growth and Cohesion* (COM (2013) 83 final) and supported by a Staff Working Document on challenges and policy options as regards LTC (European Commission 2013b), the SIP identifies several challenges in respect of social policies, including demographic ageing and the shrinking of working-age population. 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 more efficient provision of care. It briefly addresses the shortage of a health and LTC workers, 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 European Social Fund (ESF), the EU Programme for Employment and Social Innovation (EaSI) 2014-2020 and the Fund for European Aid to the Most Deprived (FEAD) – can be important measures for implementing the strategy set out in the SIP.

In addition to the initiatives undertaken or supported by the EU, a scheme to be considered which is relevant for policy in this area is the **WHO's *Global Code of Practice on the International Recruitment of Health Personnel*** (WHO 2010). This represents one of the most comprehensive attempts to provide a framework for ensuring ethically acceptable international recruitment of health care staff. It recognises, on the one hand, the right of individuals to the highest standard of healthcare, through ensuring equitable access to care both in countries of destination of migrants and in those where they originate from, and, on the other, the right of individuals to migrate, while trying to suggest ways of mitigating the negative effects of migration and maximising its positive effects, particularly in countries of origin. Its main recommendations relate to (WHO 2010):

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 countries and countries of origin to achieve mutual benefits;
5. technical and financial support for developing countries;
6. improvement of data gathering and exchange of information (for an effective implementation of the code).

B. Host country policy under review

Background

In many EU countries, demographic trends are reducing working-age population and increasing the number of older people needing LTC. In some countries, including Germany, the demand for care workers can scarcely be met by national skilled workers – since the re-training of women, older people and the non-employed is not considered be sufficient in this respect – or by further increases in the efficiency of care organisations. The recruitment of skilled care workers from abroad – while it cannot represent a sustainable stand-alone strategy to overcome current trends for a shrinking workforce (Peschner and Fotakis 2013) – could at least partly compensate for staff shortages and benefit both the LTC sector in destination countries and countries of origin, when the latter have an excess supply of labour in this regard.

Legal differentiation between EU Member States and non-EU countries

Fundamental legal differences exist between EU and non-EU third countries with regard to migrants' rights to access the labour market and the recognition of professional qualifications. For EU Member States no special work permit is necessary any longer and reciprocal recognition of professional qualifications is ensured[9]. For non-EU third countries (those outside the EEA and with which there are no bilateral agreements) the access of workers to the labour market of individual countries is subject to the national scrutiny reserve. National recruitment policies are in line with political initiatives at 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).

Political, cultural, ethical and linguistic aspects

Several factors play a crucial role in the recruitment of LTC staff in Germany. The existence of over 3 million unemployed cannot prevent severe care worker shortages, especially in rural areas, despite the activation policies adopted in recent years and the abolition of the national scrutiny reserve in 2011. Today German public opinion seems to be more in favour of recruiting foreign LTC workers than a few years ago, despite the not fully positive *Gastarbeiter* (i.e. "guest workers") experience in the 1955-73 period.

There are still, however, cultural reservations in public opinion, especially in light of the large number of foreign doctors in hospitals (who – in some remote clinics in Eastern Germany – represent the majority of medical staff). This might be challenging for the relationship of trust between care workers and patients, and for the public's hesitation in accepting the idea that key positions in the healthcare sector might go 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 marked effect on the propensity of women especially to work in the sector (Pastore and Tenaglia 2013).

[9] From January 2014 onwards, the only exceptions are some restrictions imposed discretionally by Member States on people from Croatia (potentially until 2020), since all remaining restrictions on Bulgarians and Romanians expired in December 2013.

Ethical doubts regarding the effects of recruitment concern above all the risk of draining the health care systems and negating the investment in education in countries of origin. In this regard, it is useful to distinguish between the recruitment of skilled staff and untrained entrants, as the latter strategy[10] might overcome some of these ethical issues at least.

Language represents another frequent practical problem, as care work can be meaningfully performed only when there is "sufficient" communication between carer and patient. The level of linguistic skills required is an important element in up-front costs.

Recruitment and other related costs

Well-managed migration programmes are costly. An intensive and country-specific culturally sensitive preparation and supervision of structured migration projects is very important.

In some pilot projects conducted in Germany (BfG 2013) testing cost participation models, these additional costs were covered mainly from general federal tax revenue. In the future, more structural solutions, with employers in destination countries helping to cover the costs and, if necessary, foreign employees too, should be considered. A credit model developed in these pilot projects enabled part of the preparation costs to be financed by a proportional back-payment from future wages. Legal issues of equal treatment of labour need to be considered carefully.

An additional element that needs to be kept in mind, especially in a long-term, circular migration perspective, concerns the return costs associated with programmes for assisting temporary migrants as part of a policy aimed at promoting development in countries of origin (McLoughlin and Münz 2011).

Political perspectives

LTC labour shortages should be tackled through 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. When such a strategy is not (yet) in place or has not yet produced the expected outcomes – as in the case of the current shortages of LTC workers in Germany and other EU countries – the international recruitment of such staff in a sustainable way requires careful consideration of the situation in potential source countries, in order to prevent possible 'brain', and 'care', 'drain' effects in the latter. Such a recruitment strategy needs to take account of both short and long-term effects.

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, because, for example, of economic constraints, need careful consideration, as permanent migration might exacerbate staff shortages, once the economy recovers. A stronger effort at the EU level is needed to obtain a harmonised recognition of qualifications in the LTC sector, similar to what already occurs under the Directive 2005/36/EC for healthcare workers. For this purpose, pilot training programmes for LTC workers could be

[10] An example in this respect is provided by the "Transformationspartnerschaft im Gesundheitswesen" (TAPiG) Project for Tunisian care workers in Hamburg. More information can be retrieved from the website www.projekt-tapig.de (in German) and www.coe.int/t/dg4/cultureheritage/culture/Cities/meetings/Pecs/BirteStellerHWC-TAPiG-programme.pdf (in English).

jointly set up by different Member States to test the feasibility of developing a common professional qualification path.

More systematic EU-wide initiatives are urgently needed 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.

In summary, to create a sustainable "triple-win" situation, the recruitment of care staff should aim to: (a) reduce staff shortages in destination countries; (b) reduce unemployment in source countries; (c) improve the professional qualifications of younger migrants; (d) facilitate and promote circular migration between destination and source countries; (e) combat the risk of accentuating existing gender gaps in terms of equal opportunities and treatment.

C. Policies and experiences in the peer countries

All peer countries are experiencing population ageing. The share of people aged 65 and over is rising and, according to projections, will grow further, thereby implying a higher demand for LTC. In 2013 the EC already made specific recommendations to a number of countries on growth and jobs in the light of the Europe 2020 aims, addressing some aspects of LTC, healthcare, and social protection[11]. Experts from peer countries were asked to summarise the current situation concerning the lack of skilled workers in the LTC sector and to clarify whether migration could be an appropriate response to fill the gap. In addition, the information compiled concerned strategies aimed at:

1. avoiding difficulties in meeting the requirements to care for their own ageing population in "sending countries";
2. improving the mutual recognition of professional LTC qualifications;
3. promoting "integration" in destination countries or assisting in return to source countries;
4. balancing gender opportunities.

The experience reported by the countries consulted is summarised as follows:

Belgium

In Belgium, LTC staff can be divided in two main categories: healthcare professionals (doctors, nurses, nursing assistants [*aides-soignants*]) and support staff (*aide-familiale*). The shortage is mainly for healthcare professionals (general practitioners and nurses). Three possible solutions are generally put forward as a means of overcoming the shortage: (1) increasing the job appeal; (2) implementing an active recruitment policy in the country; and (3) recruiting personnel from abroad. Up to now, the current policy options in Belgium have mainly focused on the first two solutions (Wets 2011). The proportion of migrant workers is very small but is increasing: hospitals and old people's homes (mainly in Brussels) with staff shortages hire migrant staff through recruitment agencies. In recent years, the majority of migrant nurses have come from France, the Netherlands, Portugal, Romania, Poland and Spain. In 2007, the Ministry of Health gave 208 LTC practice licenses to EU citizens and 1,169 in 2012. However, at present, Belgium has no official and comprehensive policy for recruiting LTC staff through migration, even though it has signed the WHO Global Code of Practice and applies European Laws on mutual recognition of qualifications. In Belgium the majority of LTC health workers are women: action has been taken at federal level to promote gender-balanced opportunities but none are directly related to migration in LTC.

Croatia

LTC in Croatia is not considered to be a special social risk area and is not established as a distinct welfare sector, but is covered in the broader context of means-tested social welfare policies. On February 22, 2013, the Croatian Parliament adopted an active migration policy for 2013-15 (Official Gazette no. 27/13), though it does not specifically relate to LTC. There

[11] EC recommendations are available at http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/index_en.htm

is a quota system of work permits which defines activities and professions eligible for the employment of migrants and the number of work permits to be issued each year for each of these. The quota for new work permits in 2013 was 289, 15 of which were in the healthcare section. In the case of LTC workers, the number of professionals employed by the formal sector is relatively small, due to the low level of coverage of Croatian LTC services. Croatia has not yet developed a model for integrating migrant workers or assisting them to return to their country of origin which is clear, systematic and long-term in scope. Nor has the Government yet formulated a programme to increase the number of LTC workers (national or foreign) or improve their competences, despite experts and policy analysts recognising the need to address this important issue for some time (Rusac et al. 2012). The vast majority of Croatian workers in the LTC sector, in institutionalised settings or privately employed by families, are women, who are usually paid less than men and who are at higher risk of poverty. Nevertheless, the share of women involved in the labour market in Croatia has increased continuously over the past two decades (Topolčić 2008).

Greece

Despite the steady increase in the ageing population, public home care services in Greece cover only 5.6% of older people, because elder care has never risen as high as childcare on the public policy agenda. This low level of formal service provision, with the exception of cash allowances, is to a very large extent compensated by family carers and a large number of migrant workers. Families frequently employ migrant, female, care workers, mostly from the Balkans and Eastern Europe, who mainly work in the irregular segment of the market. Because of the impact of the economic crisis, the employment of foreign labour has declined steadily, mainly because of the large increase in the availability of domestic workers due to high unemployment of Greek nationals and third country nationals who already legally reside in the country. Another procedure for attracting highly qualified workforce has been introduced recently (under Law 4071/2012), with the aim of improving the capacity to attract and retain highly qualified workers from third countries through: (a) the adoption of flexible admission conditions for highly skilled workers; (b) the introduction of a swift and flexible admission's procedure for applicants; and (c) the creation of attractive residence conditions for them and their families, including helping those who wish to move to another Member State (provisions on intra-EU mobility). Regarding LTC professionals, the results of the implementation of the above procedure were poor, since in 2013 there were no requests from employers for highly skilled workers in this area.

Hungary

The increase in the number of the older people together with a higher retirement age for women constitute the main challenges for the Hungarian LTC sector. The number of migrants in Hungary has been slowly but steadily growing, mainly from countries with large Hungarian communities such as Romania, Ukraine and the countries of the former Yugoslavia. From 2010, the Government has provided dual citizenship to Hungarians living in the redistributed territories. On the other hand emigration rose markedly last year, when approximately 85,000 people migrated to Germany, Austria, the UK, Sweden and Canada. Reasons given for this include high unemployment and economic stagnation. To halt the brain drain, especially in the healthcare sector, the Government adopted legislation stipulating that students in state-funded higher education need to sign a declaration stating that they will work in Hungary after graduating. In addition a "Migration Strategy" has been adopted,

aimed mainly at supporting Hungarian minorities and promoting integration. Recruiting skilled personnel from abroad has not become a serious issue in the formal LTC sector in Hungary, because it is a low-wage sector which fails to attract native born workers. Migrant care workers are increasingly employed as carers for older people, yet little is known about this workforce. From a gender perspective, the migrants employed by private households are usually low-paid, middle-aged women.

Poland

Available data indicate that elder care workers and LTC nurses are already in short supply. LTC is traditionally provided by families, especially women aged 50 and over. Within the system of social assistance there are several services available for senior citizens, i.e. social services (support in everyday life) or special social services (care services for people with disabilities requiring additional help from qualified medical or care staff). In order to promote the concept of active and healthy ageing and provide individuals with the opportunity to remain socially productive for as long as possible, Poland adopted the Government Programme for Social Participation of Senior Citizens 2012-2013. An additional component of the Programme is the long term senior policy project in Poland 2014-2020, which identifies priority areas where action needs to be taken within the next few years. These areas are: independent and healthy living, social participation of older citizens, employment, inter-generational solidarity and the silver economy. In addition, the EC recommended that Poland reassess its public expenditure policies to improve the targeting of social policies and to increase the cost effectiveness and efficiency of spending in the healthcare sector. With the growing participation of women in the labour market and the gradual 'de-familisation' of care tasks, many home care services have developed, mostly performed informally (both by nationals and non-nationals), often with no formal qualification required. The low prestige and low salaries of such jobs create a niche often filled by migrant women – mostly Ukrainians (Kindler, 2012). Compared to other EU countries, Poland is still not a particularly attractive destination for migrants, especially the highly-qualified. However, the Polish economy needs migrants. There is a large role here for measures to promote migration which is circular rather than permanent in nature.

Romania

The increasing number of employed women and the decreasing number of extended families, due to migration of young people, will lead to an increased need for human resources to provide LTC in the country. Romania at present has a major shortage of institutionalised services due to: (1) the small number of people who want to be trained to do the job; (2) the lack of financial motivation; (3) job related insecurity; (4) the lack of recognition of the importance of the job by society; (5) the different salary structure for the medical personnel who work in hospitals as compared with social assistance centres; (6) the lack of a clear regulation on the division of responsibility for financing social services as between the national budget, local budgets and beneficiaries; (7) the increased supply of well-paid jobs in the LTC sector in the more developed European countries. Home care is considered to be the most efficient policy for dependent elder care because it is less costly than institutional care, and also because it is preferred by people themselves, who want to maintain their independence and social network. Most family carers are women, many of whom, being elderly themselves, may also become dependent (Popa 2010). Migration is not a solution in Romania, since it is a "sending country" and very few migrants come to Romania from

other countries with the skills and professional qualifications to provide LTC. In a long term perspective, the focus should be on strategies to promote return of migrants to their home country.

Slovakia

There is no definition of LTC in Slovak legislation. Responsibility for supervision of care and services relating to LTC is divided between the Ministry of Labour, Social Affairs and Family, and the Ministry of Health. Carer qualifications, unlike nursing qualifications regulated at EU level, are set by national law. Carer jobs are poorly paid and despite growing demand for nursing services many care jobs disappear from the Slovak market year after year due to lack of public funding caused by the economic crisis and strict budgetary restrictions. The decision to take up the profession is also driven by the crisis but has a different motivation: many women, especially from regions with persistently high unemployment have no other choice but to migrate as qualified carers to countries with higher demand for these jobs, higher wages and better and more stable financial coverage of care by social insurance. A comprehensive LTC recruitment strategy should include measures relating not only to migration, language and LTC policies, but also to labour market policies (including the regulation and supervision of the recruitment practices of job agencies), "remittance-friendly" measures in the financial and banking sectors of both countries so enabling the smooth use of official sending channels, housing, health, further education policies and a set of broader cultural and civic value based measures. Employment of migrant LTC workers has become an emerging general issue due to the shortage of local care and nursing staff and there are increasing concerns about the ability to keep pace with the growing need for care. In the next ten years Slovakia will not experience a "care gap" resulting in many dependent older people not receiving social support. However, this is as a result of efforts to cover LTC needs by the closest family members.

Slovenia

Slovenia is a country of net inward migration and in healthcare and LTC services foreign workers in Slovenia come mainly from countries of the former Yugoslavia (SORS 2013). The main reasons for this, besides the geographical proximity, are cultural and language similarities that facilitate the employment of foreign workers in service jobs. In healthcare, many middle-level medical staff (nurses, medical technicians) come from Serbia, while many foreign doctors come from Croatia. Despite this, in general, the share of workers from abroad in healthcare and social services in Slovenia is well below the EU average. Currently, the Slovenian system of formal LTC is subject to strong regulation especially regarding the qualification conditions for employees and remuneration. This is one of the difficulties that foreign workers face if they want to get a job in LTC services and is also one of the reasons why the number of foreign workers employed in the formal LTC sector is small. Another difficulty is the fact that Slovenia lacks a comprehensive strategy on the employment of foreign workers in LTC. The need for LTC services is increasing (especially for community-based services), while at the same time future labour shortages are expected to occur in different sectors of the economy, including LTC. It is also possible that the future demographic situation in Slovenia will be worsened by increased emigration. The option of promoting circular migration seems to be more politically acceptable at the moment and could be developed in the form of bilateral agreements between Slovenia and other countries in the former Yugoslavia.

Spain

The enactment of the Law for the Promotion of Personal Autonomy and Care for Dependent Persons in December 2006 was a milestone in relation to LTC in Spain. This gave rise to a wide list of dependency benefits, differentiating between services, on the one hand, and cash benefits, on the other. As regards qualifications for the provision of care, different levels are set in respect of formal care while training opportunities are offered to informal carers (usually family members) in addition to the cash-for-care benefits they receive. Spain returned to being a destination country for migrants in the mid-1970s. Today, due to the economic crisis, there are significant return movements of migrants to their countries of origin and a new and increasingly significant and varied migration from Spain, especially among highly educated young people looking to develop their careers. As regards the LTC sector, at present there are no staff shortages in formal services, but since 2000 inward migration has met the considerable demand for labour in many different sectors, including elderly care. Bilateral agreements between countries have been established on residence and work permits. LTC-provider companies have had to take care of travel costs and accommodation for a short period of time and have established mutual commitments, including training. Today, there are a large number of migrants who work in LTC at all levels, especially nurses and carers. Some of them have undergone education and training organised by the Spanish Ministry of Education or continuing training organised by LTC providers, programmes implemented via NGOs and co-financed by the ESF and the Spanish government. Many migrant women are employed by households (over 70%), many of them perhaps with irregular status. Since 2010, it has become compulsory to hire people on legal contracts and therefore a modest increase in regularised migrants has been recorded. In general, to tackle LTC labour shortages and the retention of LTC workers, whether they are from other EU or non-EU countries, training is essential for addressing the possible clash of cultures on both sides. A strategy to promote circular migration could be established on the principle of "integration and return" rather than "integration or return", because both processes are complementary and can occur for the same individual during their lifetime.

Sweden

With a small, ageing population in a geographically large country, Sweden has adopted a labour migration strategy which is open and flexible (OECD 2011). The Swedish LTC system is characterised by its high level provision, and predominately publicly financed, formal care system. Up until the present day, Sweden has been able to fill demand for LTC staff partly through migrants. It is important to point out that this is not a question of labour migration as such, but of migrants who have come to Sweden for reasons other than work (e.g. those in need of protection, family reunification or training). There are no quantitative or qualitative limits to the inward migration of workers. The general approach is that labour immigration should be driven by the recruitment needs of employers – irrespective of qualification level. In recent years, Sweden has also made efforts to strengthen the connection between policies on migration and employment. However, the EC has recommended that Sweden needs to reinforce efforts to increase the labour-market integration of low-skilled young people and people with a migrant background by stronger and better targeted measures to improve their employability and the demand for these groups. In LTC, those born abroad are slightly over represented. In order to make full use of the labour force potential of the migrant population, measures for the recognition of competencies and increased vocational training are needed. The high level of requirements is believed to be a major obstacle for immigrants who lack formal LTC education and/or Swedish language skills, both when

looking for employment and in terms of eligibility for training courses. In order to promote integration, policies have been implemented that are aimed at providing migrants, who have spent four years working legally and so have contributed to the Swedish economy, with the option of applying for a permanent residence permit. Similarly, related policies are aimed at ensuring the inclusion of migrant workers in the labour market and society. As labour migration into Sweden is demand driven, rather than regulated by the State, there is no specific policy aimed at creating gender-balanced opportunities for labour migrants within the LTC sector, where women make up approximately 90% of the work force.

D. Main issues discussed during the meeting

- The first topic tackled by participants during the Peer Review meeting reflected the common concern that the **low status of LTC work** – in terms of low wages, unpleasant and/or unrewarding working conditions and low prestige – represents a crucial factor in discouraging and preventing potential candidates from starting and pursuing a career in the sector. In this respect, raising the status and improving the working conditions of migrant care workers should be seen as a priority. The WHO Global Code of Practice (2010) repeatedly attracted the attention of participants, especially as regards the question of how to include its main principles into a **comprehensive LTC staff recruitment strategy**. In particular, the debate focused on identifying ways in which such an approach can ensure that recruiting health and care workers from non-EU countries benefits all parties involved: source countries, recipient countries and care workers.
- With regard to the latter group – LTC migrants – a specific issue discussed during the meeting concerned a possible **mismatch between migrant care workers' expectations and the situation in the recipient countries** (in terms of working conditions, care tasks to be performed and wage levels, but also living conditions and social integration into the local society). In this regard, specific awareness concerning the destination country's cultural background and professional culture is crucial to avoiding misunderstandings on both sides and recruitment failures for the receiving country. In this respect, participants analysed both what aspects should be considered as a kind of "orientation package" to prepare migrant care workers in their countries of origin before their departure and what support they should receive on arrival in recipient countries. A clear exchange of views between source and destination countries on ways of funding this needs to be planned far in advance of actual recruitment.
- A partly connected topic – but of course more closely related to the professional context of LTC – concerns the difficulties of **mutual qualification and skills recognition between recipient and source countries** which still exist, especially when the latter are non-EU third countries. In particular, it was pointed out that it is crucial to make sure that, when the qualifications and competences of the care migrants recruited are not fully recognised, appropriate training opportunities are offered to them in order to close the gaps.
- Another important issue concerns the **funding mechanisms** that are needed to ensure that international care staff recruitment programmes can take place in line with the ethical principles and guidelines agreed at international level. It is crucial to clarify under what circumstances they allow or are aimed at **circular, temporary or permanent migration** of the care staff or students involved. A key strategy to make these schemes mutually beneficial is to improve working conditions in source countries so that migrants will want to return home. Another option – which is currently being evaluated by the World Bank – is to build **global training partnerships**, based on training centres established in migrant-sending countries to train students up to the standards of potential receiving countries, where they would then work once their training is finished. Funding would in this case be granted by receiving countries – as this system would be less expensive than carrying out the training themselves – while migrant-sending countries would benefit from this strategy thanks to the upgraded training system and infrastructure which would be created there.

- Finally, the **gender** element of LTC migration was addressed repeatedly during the meeting. Participants highlighted the need for specific interventions to ensure equal opportunities in implementing policies for LTC migration, especially to combat the multiple risks of underpaid and irregular employment, as well as related exploitation and abuse (e.g. lack of appropriate health care, linguistic and social exclusion).

E. Conclusions and lessons learned

- A main message emerging from the Peer Review process is that, in the long-run, the priority should be **to contain LTC demand and develop an adequate provision of care services based on the domestic workforce**. To this end, it is crucial that all possible efforts should be undertaken to make LTC jobs more attractive at national level. In particular, this means improving the practical and technical provision of domestic care but also narrowing knowledge gaps with regard to older people's needs and expectations, as well as improving the status of all professions (medical and non-medical) involved in LTC provision.
- Since, in the short term, care staff shortages might occur –because of traditional "cultural identity" of particular countries and the effect of this on their position in the international division of labour – migration should in these cases be considered as a politically viable solution only when it takes place under ethically acceptable conditions. This means, in particular, **consideration of the guidelines provided by the WHO's *Global Code of Practice on the International Recruitment of Health Personnel* (2010)**. While some of the suggestions formulated as part of this might be debatable, especially regarding their practical implementation in respect of specific indicators to identify "vulnerable" countries (i.e. countries from which no international care recruitment should take place), in these cases the way forward should not be to question the whole set of principles provided by the guidelines, but rather to propose concrete suggestion for improving the guidelines. A further remark in this respect concerns the need to identify appropriate policy means for regional, national and/or international authorities to intervene in cases of unethical recruitment behaviour by private companies (not countries), as these might be outside the scope of the WHO guidelines.
- A further lesson emerging from the Peer Review concerns the need to explicitly **include countries which are potential sources of migrants in devising LTC conceptual frameworks**. The latter usually focus on the supply and demand dynamics taking place only at national level and overlook the multidimensional impact of care migration flows in sending countries. In the current globalised world, it is most urgent to develop and use conceptual frameworks which combine theories and data that are relevant for the LTC sector together with those which accurately reflect the nature of migration. This would enable a so far largely neglected and badly needed, more in-depth consideration of policies and interventions concerning aspects such as trans-national welfare and the inter-cultural preparation and monitoring of migrant care work to take place in terms of the encounter between cultures actually involved
- The Peer Review also called for a **more precise distinction between specific LTC tasks and professions.** Based on a user-centred and integrated approach, such a detailed distinction between health (e.g. doctors, nurses and other health care staff), social and LTC professions (e.g. social workers, home helpers, care home personnel etc.), would achieve a more accurate and clear-cut definition of tasks and competencies, so supporting efforts at planning the healthcare workforce at national level to implement staff substitution strategies both in "horizontal" (i.e. between general and specialised care professionals at the same level: hospital vs. home/residential care) and "vertical" terms (i.e. between care professionals at different levels), as also suggested by the OECD (Ono et al. 2013). The relevance of this step is related to the cross-disciplinary

nature of the most neglected care needs reported by frail elderly people, such as those relating to socio-emotional and psychological aspects, which can be hardly be addressed by mono-dimensional interventions.

- Another relevant aspect considered by the Peer Review participants concerns the urgency of adopting a **life-course approach** in relation to migrant care work. The need to adopt such an innovative approach – which has been underlined by recent guidelines in ageing research in general (FUTURAGE Consortium 2011) – is justified by the need for better understanding of the long-term perspective of migrants, in order to integrate this with the too often short-term-focused viewpoint of recipient countries in search of solutions to their care staff shortages. Indeed, a more systematic consideration of such an approach would help formulate more respectful policies towards (care) migrants – which often underestimate the combined impact of age (i.e. of changes at an individual level) and of social change (i.e. of developments at a meso/family and macro/societal level) – so enabling "time" to be part of an explicit policy measure (as shown by the many rules based on this apparently "intangible" dimension, such as for instance the rotation principle, family reunification deadlines, working permits waiting periods for asylum seekers, etc.) (Lamura 1998). A useful strategy in this respect would also be to shift from the more traditional approach based on "integration" policies – which imply that migrants want to settle in recipient countries – to the more flexible and egalitarian concept of "interaction" (which underlines more the need for a reciprocal respect of necessarily different cultural identities, away from an "assimilation" strategy). For this purpose, it is however essential to recognise the usually weaker position of LTC workers (such as nurses or home helpers) compared to that of doctors in many countries (including the Peer Review host country Germany), which requires an assurance of LTC workers to be adequately represented and their basic rights to be protected (keeping in mind lessons learnt such as those emerging from the already mentioned TAPiG project for Tunisian care workers in Hamburg).

- A crucial distinction to bear in mind is also that between **migration related to education and training and that which involves remunerated care work**. This is relevant as the former implies a qualification and up-skilling path for migrants, which is not necessarily implied by the latter. While training opportunities represent, in the eyes of recipient countries, a benefit only if it is paid by migrants themselves or by their sending countries or if training is followed by a relatively long period of temporary migration (to achieve a return of the sum invested in the training of foreign students), care work migration has to be distinguished between transitory (or circular) and permanent. Under "normal" circumstances (i.e. in the case of a usual working career), the latter is clearly a win situation for the recipient country and can become a win situation for the sending country only if remittances reach a substantial amount over time (so improving the socio-economic situation of the migrant's family left behind). Circular migration can be a short-term solution to shortages in recipient countries and high unemployment in sending countries; by up-skilling temporary migrants it can also represent a gain for both migrants themselves and the care system in the sending country.
- In addition, participants in the Peer Review stressed the importance of **cooperation among all relevant stakeholders**, to be reached at national and international level, in order to achieve a more efficient match between supply and demand of LTC professionals. In particular, regional and local governments – which are, in most cases, the bodies responsible for the provision of health and social care – should discuss

and address EU priorities, together with others in both the non-profit and market sectors, and in coherence with other policy areas such as education and training, entrepreneurship, labour market and infrastructure.

- With regard to the **specific German case**, the discussion highlighted the need to tailor LTC provision according to the country specific features, by distinguishing even existing inequalities and differentiated needs at the regional and rural-urban level. Positive and negative lessons from previous experience should be used as a background to formulate future policies without repeating previous mistakes. The most relevant questions in this respect are the following: should "circular migration" be a choice or an obligation for migrants working in the care sector? How does the concept of "circular migrant" differ from that of "guest worker" used until the 1970s? Can the reform adopted in 2012 to allow full mobility for medical doctors be extended to nurses too? Can nurses become "highly qualified staff" by introducing a qualification path enabling them to reach a "nursing university degree" similarly to that in other EU countries? If shortages of care workers are seen as urgent, why not recruit LTC staff from neighbouring EU Member States currently affected by high unemployment (instead of looking to non-EU third countries)? What opportunities might come from re-arranging the "vertical/horizontal" distribution of different care tasks (e.g. should the task of "washing" patients fall under "health care", "social care" or "home help")?

F. Contribution of the Peer Review to Europe 2020 and the Social Investment Package

The results of this Peer Review have the potential to address different objectives of the Europe 2020 strategy (European Commission 2010). A very straightforward contribution can be identified with regard to the target of achieving an **employment rate of 75% of the 20-64 age group**. The LTC sector is indeed one of the most promising areas for job creation, especially for women, mainly in part-time employment, who are often hired after a period of economic inactivity (van der Velde et al. 2010) and are of mature age (Martin and King 2008). An improved and more widespread use of the tools and strategies analysed in this Peer Review would enable EU-Member States to improve the matching between demand and supply of LTC workers, so increasing employment opportunities for both migrant and non-migrant workforces.

This Peer Review is also likely to contribute significantly to helping achieve another crucial Europe 2020 target, namely that of **reducing the number of people at risk of poverty and social exclusion by at least 20 million**. On the supply side, this aim could be supported through the overall increase of the number of LTC providers via a smoother and more qualified employment of migrant care workers, so reducing the number of unemployed (and therefore at-risk-of poverty) across the EU. On the demand side, the easier access to LTC work made possible by the proposed suggestions is likely to reduce the number of service users and their carers suffering from social exclusion due to their vulnerable position.

In addition, the issues discussed during this Peer Review process have the potential to contribute to the **Social Investment Package (SIP) strategy** (European Commission 2013a, 2013b), especially regarding the progress towards a financially sustainable and socially adequate protection against the risk of LTC. As migrant workers are becoming the cornerstone of the LTC sector, the issues discussed in this paper should be considered in the context of wider EU policy guidance and be adapted to national contexts through country-specific recommendations. Without exploiting the full potential of LTC workers, it would not be possible to move towards the goals of the SIP, e.g. **combining preventive measures** of healthy and active ageing with **productivity drives in care provision** and **increasing the ability of older people to live independently,** even when they become frail and disabled (European Commission 2013b).

However, to make sure that these targets are also achieved through the proposals made in this Peer Review, it is necessary that such proposals are **effectively implemented so as to shape national policies**, and in connection with other EU-based support programmes, such as those relating to the European Regional Development Fund and the European Social Fund , which include additional measures to facilitate the integration of migrants and to provide training for staff with diverse cultural and migration backgrounds. To this end, the results of this Peer Review should be brought to the attention of **regional and local governments** and, through them, to people at large, as these institutions are in many countries responsible for related policy areas such as education, training, entrepreneurship, labour market and infrastructure. The **European Union's Committee of the Regions** might play a major role in raising awareness about these topics among regional and local authorities, and should therefore be systematically involved in their dissemination too.

References

BfG (Bundesministerium für Gesundheit) (2013). Erhöhte Bedarfe in der Pflege: Zirkuläre Migration von Pflegefachkräften. Host Country paper prepared for the Peer Review "Filling the gap in long-term professional care through systematic migration policies", Berlin, August 2013.

Council of the European Union (2009). Directive on the conditions of entry and residence of third-country nationals for the purposes of highly qualified employment. Council Directive 2009/50/EC of 25 May 2009. Brussels: Council of the European Union. Retrieved from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32009L0050:EN:NOT

European Commission (2003). Decision implementing Council Regulation (EEC) No 1612/68 as regards the clearance of vacancies and applications for employment. Decision 2003/8/EC of 23 December 2002. Brussels: European Commission. Retrieved from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32003D0008:EN:HTML

European Commission (2010). Europe 2020 - A strategy for smart, sustainable and inclusive growth. COM(2010) 2020 final. Brussels: European Commission. Retrieved from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52010DC2020:EN:NOT

European Commission (2012a). Towards a job rich recovery. COM(2012) 173 final. Brussels: European Commission. Retrieved from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2012:0173:FIN:EN:PDF

European Commission (2012b). Exploiting the employment potential of the personal and household services. Staff Working Document SWD(2012) 95 final accompanying COM(2012) 173 final. Retrieved from http://ec.europa.eu/social/BlobServlet?docId=7623&langId=en

European Commission (2012c). Action Plan for the EU Health Workforce. Commission Staff Working Document SWD(2012) 93 final accompanying COM(2012) 173 final. Brussels: European Commission. Retrieved from http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf

European Commission (2013a). Towards Social Investment for Growth and Cohesion – including implementing the European Social Fund 2014-2020. COM(2013) 83 final. Brussels: European Commission. Retrieved from http://ec.europa.eu/social/BlobServlet?docId=9761&langId=en

European Commission (2013b). Long-term care in ageing societies - Challenges and policy options. Commission Staff Working Document accompanying COM(2013) 83 final. Brussels: European Commission. Retrieved from http://ec.europa.eu/social/BlobServlet?docId=9769&langId=en

European Council (2012). Compact for Growth and Jobs. Annex to the European Council Conclusions EUCO 76/12 of 29 June 2012. Brussels: European Council. Retrieved

from http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ec/131388.pdf#page=8

European Union (2005). Directive on the recognition of professional qualifications. Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005. Brussels: European Union. Retrieved from http://ec.europa.eu/internal_market/qualifications/policy_developments/legislation/index_en.htm

European Union (2011a). Directive on a single application procedure for a single permit for third-country nationals to reside and work in the territory of a Member State and on a common set of rights for third-country workers legally residing in a Member State. Directive 2011/98/EU of the European Parliament and of the Council of 13 December 2011. Brussels: European Union. Retrieved from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32011L0098:EN:NOT

European Union (2011b). Regulation on freedom of movement for workers within the Union Text with EEA relevance. Regulation (EU) No 492/2011 of the European Parliament and of the Council of 5 April 2011. Brussels: European Union. Retrieved from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32011R0492:EN:NOT

FUTURAGE Consortium (2011). Futurage: A Road Map for European Ageing Research. Report by FUTURAGE Consortium. Retrieved from http://futurage.group.shef.ac.uk/assets/files/Final%20road%20map/FUTURAGE%20A%20Road%20Map%20for%20European%20Ageing%20Research%20-%20October%202011.pdf

Kindler M. (2012). A Risky Business? Ukrainian Migrant Women in Warsaw's Domestic Work Sector. Amsterdam: Amsterdam University Press.

Lamura G. (1998). Migration und kommunale Migrationspolitik. Wiesbaden: Deutscher Universitaetsverlag.

Lamura G., Chiatti C., Barbabella F. & Di Rosa M. (2013). Migrant long-term care work in the European Union: Opportunities, challenges and main policy options. Discussion paper for the Peer Review Meeting "Filling the gap in long-term professional care through systematic migration policies". October 2013. Retrieved from http://ec.europa.eu/social/BlobServlet?docId=11116&langId=en

Martin B. & King D. (2008). Who Cares for Older Australians? A Picture of the Residential and Community-based Aged Care workforce, 2007. Australian Government, Department of Health and Ageing/National Institute of Labour Studies, Flinders University and Commonwealth of Australia.

Matrix Insight (2012). EU level Collaboration on Forecasting Health Workforce Needs, Workforce Planning and Health Workforce Trends – A Feasibility Study. Brussels: European Commission. Retrieved from http://ec.europa.eu/health/workforce/docs/health_workforce_study_2012_report_en.pdf

McLoughlin S. & Münz R. (2011). Temporary and circular migration: opportunities and challenges. Working Paper No. 35. Brussels: European Policy Centre. Retrieved from www.epc.eu/documents/uploads/pub_1237_temporary_and_circular_migration_wp35.pdf

OECD (2011). Recruiting Immigrant Workers: Sweden 2011. Paris: OECD.

Ono T., Lafortune G. & Schoenstein M. (2013). Health Workforce Planning in OECD Countries: A Review of 26 Projection Models from 18 Countries. OECD Health Working Papers No. 62. Paris: OECD. Retrieved from www.oecd-ilibrary.org/docserver/download/5k44t787zcwb.pdf?expires=1378839570&id=id&accname=guest&checksum=F8B79D74C507F215352350D161C467C2

Pastore F. & Tenaglia S. (2013). Ora et non Labora? A Test of the Impact of Religion on Female Labor Supply. IZA Discussion Paper No. 7356. Bonn: IZA. Retrieved from http://ftp.iza.org/dp7356.pdf

Peschner J. & Fotakis C. (2013). Growth potential of EU human resources and policy implications for future economic growth. Luxembourg: Publications Office of the European Union. Retrieved from http://ec.europa.eu/social/BlobServlet?docId=10939&langId=en

Popa D. (2010). The Long-Term Care System For The Elderly In Romania. ENEPRI Research Report No. 85. Retrieved from www.ancienlongtermcare.eu/sites/default/files/ENEPRI%20_ANCIEN_%20RR%20No%2085%20Romania.pdf

Rusac, S., Laklija, M. & Milić Babić, M. (2012), Strategija suočavanja članova obitelji oboljelih od Alzheimerove bolesti, Hrvatska revija za rehabilitacijska istraživanja 48(2): 86-97.

SORS (Statistical Office of Republic of Slovenia – Statistični urad Republike Slovenije) (2013). Cross country migrations. SI-Stat Data portal. Retrieved from http://pxweb.stat.si/pxweb/Database/Dem_soc/05_prebivalstvo/40_selitve/05_05N10_meddrzavne/05_05N10_meddrzavne.asp /10.10.2013

Topolčić D. (2008). Udio žena na tržištu rada, obrasci radne karijere i uloga države, Institut društvenih znanosti Ivo Pilar, (6)98, 1023-1046.

van der Velde, F., Verijdt, F. & Arnold, E. (2010). De arbeidsmarkt voor lagere functies in de zorg: veel vissen in de vijver. OEZW19. Utrecht: Prismant.

Wets J. & De Bruyn T. (2011). La migration: la solution aux pénuries de personnel dans le secteur des soins et de la santé? Bruxelles: Fondation Roi Baudouin.

World Health Organization (2010). WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva: WHO. Retrieved from http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf

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Filling the gap in long-term professional care through systematic migration policies

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Filling the gap in long-term professional care through systematic migration policies

Host country: **Germany**

Peer countries: **Belgium - Croatia - Greece - Hungary - Poland - Romania - Slovakia - Slovenia - Spain - Sweden**

Stakeholders: **European Hospital and Healthcare Federation (HOPE), World Bank, German Marshall Fund (United States)**

Ageing populations across Europe have led to increased demand for healthcare professionals. Although mobility within the EU is one method of meeting increased demand, it can drain other Member States of much-needed staff. Germany is therefore recruiting and training non-EU migrants in compliance with the WHO Global Code of Practice on the International Recruitment of Health Personnel.

The Peer Review in Berlin (23-24 October 2013) provided the opportunity for peer countries to explore the German approach of recruiting and training non-EU migrants.

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