

Public services

# Long-term care workforce: Employment and working conditions



Produced for the European Commission in the context  
of the forthcoming report on long-term care, jointly prepared  
by the European Commission and the Social Protection Committee



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European Foundation  
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*This report presents the results of research conducted largely prior to the outbreak of COVID-19 in Europe in February 2020. For this reason, the results do not fully take account of the outbreak.*

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# Contents

<b>Executive summary</b>	<b>1</b>
<b>Introduction</b>	<b>3</b>
Defining LTC and the LTC workforce	3
Data sources and limitations	4
EU policy relevance	4
<b>1. Mapping the LTC workforce: Composition and trends</b>	<b>7</b>
Workforce size	7
Female workforce	10
Older workforce	10
Migrants and mobile citizens	11
Staff turnover	12
Staff shortages	13
<b>2. Nature of employment</b>	<b>19</b>
Public versus private sector employment	19
Indefinite versus fixed-term contracts	21
Zero-hour contracts	22
Self-employment	22
Platforms	24
Undeclared work	25
Live-in care	26
<b>3. Working conditions</b>	<b>29</b>
Job quality	29
Earnings	29
Working time	38
Work intensity and environment	43
Physical and psychological health effects of the working environment	46
Skills development: More training, and more need for training	48
Usefulness of the work	48
<b>4. Collective bargaining</b>	<b>51</b>
<b>5. Policies aimed at the long-term care workforce</b>	<b>55</b>
Policies to make the sector more attractive	55
Policies to combat undeclared work	56
Policies for live-in carers	57
<b>6. Discussion and conclusions</b>	<b>59</b>
Overview of main issues	59
Policy pointers	65
<b>Bibliography</b>	<b>67</b>
<b>Annex: Network of Eurofound Correspondents</b>	<b>73</b>

## Country codes

<b>AT</b>	Austria	<b>FI</b>	Finland	<b>NL</b>	Netherlands
<b>BE</b>	Belgium	<b>FR</b>	France	<b>PL</b>	Poland
<b>BG</b>	Bulgaria	<b>HR</b>	Croatia	<b>PT</b>	Portugal
<b>CY</b>	Cyprus	<b>HU</b>	Hungary	<b>RO</b>	Romania
<b>CZ</b>	Czechia	<b>IE</b>	Ireland	<b>SE</b>	Sweden
<b>DE</b>	Germany	<b>IT</b>	Italy	<b>SI</b>	Slovenia
<b>DK</b>	Denmark	<b>LT</b>	Lithuania	<b>SK</b>	Slovakia
<b>EE</b>	Estonia	<b>LU</b>	Luxembourg		
<b>EL</b>	Greece	<b>LV</b>	Latvia	<b>NO</b>	Norway
<b>ES</b>	Spain	<b>MT</b>	Malta	<b>UK</b>	United Kingdom

# Executive summary

## Introduction

People in the EU are living longer and, while they are generally healthier, long-term care (LTC) needs are increasing. As a proportion of the overall workforce, the LTC workforce has expanded steadily, by one-third, over the past decade and is expected to grow further. It is thus becoming increasingly important to know more about the LTC workforce. The LTC sector has been badly affected by the coronavirus (COVID-19) crisis, and often has not been equipped well to cope. It is hard to predict the impact of this crisis on workforce dynamics, but the trend of a growing need for LTC workers is likely to continue.

This report contributes to the discussion by investigating employment and working conditions in LTC and by providing information about the LTC workforce's size, characteristics and shortages. It discusses policies to address shortages, undeclared work and the situation of carers who live with the care receiver. The research combines input from the Network of Eurofound Correspondents in each EU Member State, the UK and Norway with analysis of EU survey data and literature.

## Policy context

LTC contributes to the quality of life and employment prospects of people with LTC needs, including older people and people with disabilities, enabling them to enjoy their rights (in line with the European Pillar of Social Rights (EPSR) and the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)). The LTC workforce is key in delivering a person-centred quality service.

The LTC sector includes many low-paid jobs with specific challenges around working conditions. This expanding sector is thus important to consider in the EU's efforts to address poverty and precarious working conditions, and its debate on increasing the minimum wage. The EU has implemented multiple directives and framework agreements on aspects of working conditions that appear problematic for LTC. Being female dominated, LTC is also an important sector when considering gender inequality.

Informal care provided by relatives or friends plays a large role in meeting LTC needs, but results in loss of workforce, health issues for the carer and, as most informal carers are female, issues around gender inequality. If Member States with the least developed LTC systems are to improve access to LTC, as recommended by the European Commission's 2018 ageing report and country-specific recommendations, they will need to increase their LTC workforce. This comes on top of the additional staff required to respond to increased LTC needs in all Member States. Staff shortages are already affecting LTC delivery in specific areas.

## Key findings

### Employment trends and workforce

- In the EU, 6.3 million people work in the LTC sector. This number compares with 44 million people providing frequent informal LTC to family or friends.
- Two in five (42%) LTC workers work part time, double the rate for the entire workforce (19%). Many do so because they cannot find full-time work (30% in non-residential LTC, 20% in residential LTC).
- Self-employment in LTC is rare (1.9%) compared with self-employment in the entire workforce (14.2%) and is concentrated in home care. Permanent contracts are relatively common in LTC, especially in residential LTC.
- Four in five (81%) formal LTC workers are female. The proportion of workers aged 50 years or older is higher than in other sectors and has increased faster, from 28% in 2009 to 38% in 2019.
- More than in healthcare, migrants and mobile workers form an important part of the LTC workforce (mainly in domestic LTC in some countries). Cross-border work is frequent in cases where differences in working conditions and salaries between bordering areas are large.
- Staff shortages differ within and between countries but are often most urgent for skilled nurses. They depend on supply and demand dynamics, which are sensitive to policies.
- Statistics on LTC are often compiled alongside those for other social services or healthcare sectors, or are lacking, especially for domestic LTC workers, who play a large role in some Member States.

### Working conditions

- Seven in ten (71%) LTC workers indicate that they always 'have the feeling of doing useful work', which is more than in healthcare (66%) and in the entire workforce (50%).
- However, only 22% of LTC workers are 'very satisfied' with their working conditions, fewer than in the entire workforce (26%).
- LTC workers often report that they do not believe they will be able to keep working until the age of 60.
- LTC workers often do shift work, in particular rotating shifts, and feel that they have no say in their working arrangements; they are often requested to come to work at short notice. Evening, night and weekend work is particularly frequent in residential LTC.
- Two-fifths (40%) of LTC workers report lifting or moving people more than three-quarters of the time (compared with 5% of all workers and 23%



in healthcare). Many LTC workers report handling infectious materials. LTC workers are less likely than healthcare workers to feel very well informed about health and safety.

- LTC workers report experiencing adverse social behaviour (such as verbal abuse, humiliating behaviour, physical violence and threats) more often than healthcare and other workers.
- Large sections of the LTC workforce are paid well below the national average wage (carers, social carers, assistant nurses). The best-paid professions in LTC are usually paid around the national average wage (specialist nurses, social workers, therapists). Pay in the private sector is usually worse than that in the public sector.
- Domestic LTC work, where the care receiver is the employer, is among the lowest paid and least regulated type of LTC work. It falls outside the scope of labour inspectorates. Undeclared work is concentrated in domestic LTC and is relatively uncommon in other forms of LTC.
- Live-in care (a type of domestic LTC where the carer lives with the care receiver) comes with additional risks with regard to working conditions. It is relatively common in Austria, Cyprus, Germany, Greece, Italy, Malta and Spain, and is increasing in some other Member States, where it is currently restricted to a small group of people with specific care needs (for example, the Netherlands) or high incomes (for example, Poland).

## Policy pointers

- Interpersonal aspects of work are key in LTC. To guarantee high-quality LTC and address staff shortages, it is important to value human resources and improve working conditions in the sector.
- To address staff shortages, measures could target part-time workers who want to increase their hours, unemployed and inactive former informal carers, LTC workers who want to delay their retirement and young students-to-be. Men in particular could be targeted. However, for these measures to be effective, more sustainable working conditions are needed.
- As the LTC sector grows, it is increasingly important to acknowledge the specific physical risks that LTC workers face, including those relating to lifting people. The COVID-19 crisis has shown that LTC workers must be better prepared to work safely in potentially infectious environments. The physical demands of LTC and the risk of infection from illnesses such as

influenza/COVID-19 tend to affect older workers, who are overrepresented in LTC, more severely.

- LTC workers have a high risk of developing mental health problems because of the high levels of emotional demands of the job and exposure to adverse social behaviour at work. With the growing LTC workforce, it is particularly important that this is addressed by policymakers. Mental health problems are associated with high costs to society. Ignoring them affects women disproportionately as more women than men are employed in the LTC sector.
- Better staffing levels can reduce the need for short-notice work and, together with increased professionalisation, training and improved processes, can reduce the physical and mental health challenges of LTC. More time with service users, fewer administrative tasks, greater autonomy and increased professionalism can also contribute to better services.
- Home and community-based care services are key in enabling people with LTC needs to stay in the community. The COVID-19 crisis may accelerate the move away from large-scale residential LTC. However, the care user's home as work environment is hard to regulate and control. Training (for example in kinaesthetics), aggression management, technology and better staffing can help to improve working conditions.
- Domestic LTC work in particular needs to be better covered by regulations and collective agreements, which should be enforced, with attention given to the specific risks of care work and ensuring that travel between care users is remunerated appropriately.
- Live-in care, where the LTC worker lives in the care receiver's home, is associated with risks around working conditions and quality of care. Regularisation can be facilitated by attractive registration procedures. However, if good access to a flexible range of high-quality LTC services is offered, live-in care is rarely needed.
- Where public funding plays a role in LTC, governments can use this to improve working conditions, for instance through requirements in public procurement. Undeclared LTC work can be addressed by improving access to flexible, high-quality LTC, with public support restricted to registered providers and declared care.
- Acknowledging LTC as a distinctive sector in data collection and collective agreements or regulations, and improved coverage of collective bargaining, can help in improving evidence for policies, creating a better working environment and enhancing service quality.



# Introduction

With an ageing EU population, long-term care (LTC) needs are increasing. A large share of LTC is currently provided by informal carers. Such care by relatives or friends is thus a key resource and can be the preference of those involved, but it is associated with a cost to society (loss of workforce, health problems for carers) and sustainability challenges. Formal LTC is not well developed in many Member States and needs to be expanded to provide adequate care. In countries with better developed LTC services, demand is increasing while services are already facing staff shortages. LTC is a service where interpersonal interactions between user and caregiver are particularly important, and the quality and availability of the service is closely related to the quality of working conditions and the availability of staff. For a sector that is growing in importance, while also facing workforce challenges, it is key for EU policymakers to have a better understanding of the composition of the LTC workforce and the types of employment and working conditions of LTC workers. This report aims to contribute to the discussion by mapping available data from Member States and EU-level surveys. It also discusses policies that have been implemented to make the sector more attractive and to address specific LTC workforce issues, including those that relate to LTC workers in situations where working conditions can be most precarious: those who live with the care receiver or who are involved in undeclared work.

## Defining LTC and the LTC workforce

In this report, LTC is defined as ‘a range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care. The daily living activities for which help is needed may be the self-care activities that a person must perform every day (activities of daily living, or ADLs, such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling bladder and bowel functions) or may be related to independent living (instrumental activities of daily living, or IADLs, such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone)’ (Social Protection Committee and European Commission, 2014, p. 11). People of all ages may need LTC, including young people with disabilities. However, needs increase with age and older people account for most LTC users. This is increasingly the case as the EU’s population ages.

Excluded from this definition are palliative care (in hospices), hospital or primary care (even if in some countries these services, in practice, function as community/residential care providers), childcare (except LTC for children with disabilities) and drug rehabilitation/substance abuse care. This report is also not about

informal LTC provided by relatives or acquaintances of the person with LTC needs, which is usually unpaid, but is sometimes paid for from care allowances or by municipalities. Mandatory community service (usually performed instead of military service) and voluntary work are also excluded.

LTC workers include people who provide such LTC services. They work in residential care, home care (in sheltered or non-sheltered homes) and community (day) care services, which can be publicly or privately provided or financed. LTC workers may also be privately employed by households.

Information is often not easily available for workers who fall under this definition, and the report includes information about groups of workers who do not perfectly overlap with it. However, the definition serves as a broad point of reference.

The roles and skills of LTC professions vary between countries, even for professions with similar names, making it difficult to define LTC workers by their job title (OECD, 2020). In several sections of this report (for example, the section on ‘Staff shortages’), the focus is on ‘care professions’. However, it can be debated what constitutes a ‘care profession’ (for example, is preparing food especially for older people a care profession, and is handing this food over to an LTC user a care profession?). People who do non-care work in LTC may also do care work; a line is particularly difficult to draw in the home care setting (Baga et al, 2020). However, broadly speaking, care occupations in LTC mostly fall under the following International Standard Classification of Occupations (ISCO-08) codes:

- subgroups of nurses: 2221 Nursing professionals and 3221 Nursing associate professionals (also including non-LTC nurses, such as paediatric and anaesthetic nurses)
- subgroups of personal care workers in health services (532): 5321 Health care assistants, 5322 Home-based personal care workers, 5329 Personal care workers in health services not elsewhere classified
- other professions such as 2264 Physiotherapists and 2266 Audiologists and speech therapists

However, in particular when analysing EU datasets, this report focuses on the LTC sector, regardless of profession, and so also includes workers other than ‘carers’ (for example, support workers such as cooks, cleaners and administrators). LTC workers broadly are employed in the following NACE Rev. 2 classification categories:

- ‘residential care activities’ (NACE 87): residential nursing care activities (NACE 87.1), residential care activities for mental retardation, mental health and substance abuse (NACE 87.2), residential care activities for the elderly and disabled (NACE 87.3) and other residential care activities (NACE 87.9). It should

be noted that ‘care activities for substance abuse’ are not included in the LTC definition used in this report, but cannot be disaggregated from the NACE categorisation

- ‘social work activities without accommodation for the elderly and disabled’ (NACE 88.1)

The LTC sector may include certain workers employed in ‘human health activities’ (NACE 86), in particular ‘other human health activities’ (NACE 86.9). It may also include workers in ‘activities of households as employers of domestic personnel’ (NACE 97). However, the focus here is on NACE codes 87 and 88.1, which cover 69.3% of the EU27’s social services workforce (defined as all workers under NACE codes 87 and 88) (Labour Force Survey (LFS) 2019). It excludes the 30.7% of social service workers employed in activities without accommodation other than for older people and people with disabilities: child day-care activities (NACE 88.91) and social, counselling, welfare, refugee, referral and similar services (NACE 88.99).

## Data sources and limitations

This report draws together evidence from the literature, responses from the Network of Eurofound Correspondents<sup>1</sup> to Eurofound’s questionnaire, received between February and August 2020, and EU survey data from the 2015 European Working Conditions Survey (EWCS), Eurostat’s 2009–2019 LFS and the 2010, 2014 and (only for Table 6) 2018 Structure of Earnings Survey (SES). The Network of Eurofound Correspondents prepared its input from December 2019 to August 2020.

LFS data are used mainly for the ‘Profile of workers in the sector’ and ‘Nature of employment’ chapters and the ‘Working time’ section. Yearly weighted data are reported, unless indicated otherwise. EWCS data enrich these findings by providing more detailed information for the ‘Working conditions’ chapter, generally when this is unavailable from the LFS (which provides more recent data and includes a larger sample size). SES data are used for the section on ‘Earnings’. Eurostat provided SES and LFS extractions in 2020.

In the EWCS and LFS data analysis, people working in LTC are defined as those working under NACE codes 87 and 88.1, referred to as residential and non-residential LTC, respectively. These workers are generally compared with people working in healthcare (defined as NACE 86). The comparison is particularly relevant as several groups of workers (especially nurses) can be employed in both LTC and healthcare. For the SES data analysis, NACE codes 87 and 88 are used, as NACE 88.1-level results are unavailable. While the EU survey data analysis focuses on the LTC sector (see section on ‘Defining LTC and the LTC workforce’), differences between types of professions within this sector are highlighted when discussing the EWCS results, where most LTC workers included in

the analysis are ‘personal care workers’ (44%), ‘health associate professionals’ (10%), ‘health professionals’ (8%) and ‘cleaners and helpers’ (7%). The Network of Eurofound Correspondents’ input is often restricted to care occupations.

Because of the limited sample size, EWCS 2015 results are mainly reported at EU level.<sup>2</sup> EWCS data relate to respondents’ main paid job where they spend most hours; therefore, for LTC workers who work more hours in a non-LTC job, the LTC work is excluded. The SES data presented are restricted to organisations with 10 or more employees.

## EU policy relevance

Because of the ageing population in the EU, the LTC workforce has expanded and is likely to grow further, increasing in relevance from a policy perspective. During the coronavirus (COVID-19) crisis, LTC has been identified as an essential service, and often has not had the resources required to respond adequately. The Federation of European Social Employers and the European Public Service Union (2020a), in a joint position paper on recruitment and retention in European social services, stated that ‘[r]ecruitment and retention in social services are issues that require immediate and urgent responses, including through social dialogue at national and European level’. A later joint position paper, on preparing the social services sector for the COVID-19 resurgence and increasing its resilience, argues that ‘the COVID-19 pandemic puts enormous pressure on the social services sector, exacerbating already pre-existing financing and staffing difficulties’ (Federation of European Social Employers and the European Public Service Union, 2020b).

The European Commission’s country-specific recommendations have called on several Member States to improve access to LTC (Eurofound, 2020). This is in line with the European Pillar of Social Rights (EPSR), which states that ‘Everyone has the right to affordable long-term care services of good quality, in particular home-care and community-based services’ (European Commission, undated). There have also been calls for person-centred services (Social Protection Committee and European Commission, 2014), and, in line with the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), Member States have embarked on deinstitutionalisation processes. Increases in home and community-based LTC have an impact on the way that services are provided and on jobs (United Nations, undated).

Lower-income Member States generally have less well-developed LTC systems, and face challenges in improving them in the context of ageing societies and limited budgets. One problem faced by Member States with lower wages is that LTC staff are attracted to better working conditions (especially higher wages) in other Member States. In higher-income countries with better access to

<sup>1</sup> Most national information in this report comes from these contributions, including when no source is mentioned. Detailed unpublished information for the 27 Member States, Norway and the UK can be requested.

<sup>2</sup> As the EWCS analysis started before 31 January 2020, it includes aggregate information for the EU27 and the UK. The LFS and SES analyses were conducted later and so include aggregate information for the EU27.

LTC, barriers to expanding LTC services can stem less from financial and more from human resource constraints; however, financial resources are also an important determinant in these countries. Improving recruitment and retention in the LTC workforce can be an important factor in improving the efficiency of LTC services according to the 2014 report by the Social Protection Committee and European Commission on adequate social protection for long-term care needs (Social Protection Committee and European Commission, 2014; a follow-up report is expected in 2021).

The EU has introduced rules that are relevant for aspects of working conditions, which, according to the above-mentioned report, are of concern in LTC. This is the case, for instance, for mental health risks and frequent harassment at work. The concept of harassment was introduced into the amendment to Directive 76/207/EEC on the implementation of the principle of equal treatment for women and men in employment, vocational training and promotion, and working conditions (revised by Directive 2002/73/EC). More recently, EU policy on this issue has been developed through the 2007 autonomous framework agreement on harassment and violence at work. The Framework Directive on Occupational Safety and Health has set minimum safety and health requirements. A 2014 interpretative document further points to the responsibility of employers to take risk prevention measures for workers' mental health. The EPSR further includes a principle on a 'healthy, safe and well-adapted work environment'.

The LTC sector has a particularly high proportion of part-time workers. Rules are set by the Working Time Directive, the Work-Life Balance Directive and the 1997 framework agreement on part-time work. In the context of the various forms of employment in LTC, rules are further set by the 1999 framework agreement on fixed-term work and the 2007 Directive on Temporary Agency Work. The European Platform tackling undeclared work and the European Economic and Social Committee's (EESC) 2016 opinion on the rights of live-in carers are also key for certain sections of the LTC workforce. The 2019 Directive on Transparent and Predictable Working Conditions followed up on the EPSR in promoting more secure and predictable employment while ensuring labour market adaptability and improving living and working conditions.

As the LTC sector includes many low-paid jobs, it is also relevant to the EU policy objective to decrease poverty and the European Commission's October 2020 proposal for a directive on adequate minimum wages.

The LTC workforce is largely female; it is thus an important sector to look at for gender equality. The EU's Gender Equality Strategy 2020–2025 points out that '[m]ore women than men work in low-paid jobs and sectors, and in lower positions. Discriminatory social norms and stereotypes about women's and men's skills, and the undervaluation of women's work are some of the contributing factors'. It calls for an updated Skills Agenda for Europe and a proposal for a Council recommendation on vocational education and training to support gender balance in traditionally male- or female-dominated professions, and address gender stereotypes and gender gaps in education and training (European Commission, 2020a). The EPSR states that '[e]quality of treatment and opportunities between women and men must be ensured and fostered in all areas, including regarding participation in the labour market, terms and conditions of employment and career progression' (European Commission, undated). EU funding contributes to combating gender segregation in certain professions and addressing the unequal representation of girls and boys in some sectors of education and training.

There is a second gender aspect to LTC. LTC is currently provided mainly by informal carers (relatives or friends of the person with care needs). Most of them are female. Access to good-quality formal LTC services prevents health problems, facilitates social inclusion, and for informal carers of working age, facilitates employment and improves work-life balance. This can lead to reduced healthcare and social security expenditure, and increased income tax revenue (EESC, 2014; European Commission, forthcoming). A good LTC workforce is needed to ensure access to good-quality formal LTC services (European Commission, 2020b). A third gender aspect is that more women than men have LTC needs because, on average, women live longer (EIGE, forthcoming). Therefore, as users of LTC they are more likely to be impacted by LTC workforce challenges.

Geographical inequalities in access to LTC are partly caused by staff shortages, which differ between and within Member States, with more shortages in some rural areas. The European Commission (2020c) has assessed the impact of demographic change on different groups in society and on areas and regions disproportionately affected, and how best to support regions, notably to improve infrastructure and access to services. To ensure access to good-quality LTC, its workforce is key. For its Green Paper on ageing, expected in late 2020, the European Commission will assess whether or not social protection systems are fit to face the needs of the ageing population.



# 1 Mapping the LTC workforce: Composition and trends

## Workforce size

In the EU27, about 6.3 million people work in LTC, which is 3.2% of the EU's entire workforce (Figure 1). This compares with 44 million, or 12% of the adult population, being frequent informal long-term caregivers, that is, people aged 18 years or over who care for one or more disabled or infirm family member, neighbour or friend, of any age, more than twice a week.<sup>3</sup>

There are large differences between Member States in terms of the size of the LTC workforce. The LTC workforce as a share of the entire workforce ranges from 0.3% in Greece to 7.1% in Sweden (Figure 1). In seven Member States, LTC workers comprise 1.5% or less of the workforce (Bulgaria, Cyprus, Estonia, Greece, Latvia, Poland, Romania). At the upper end of the spectrum are seven Member States where LTC workers comprise over 4.0% of the workforce (Belgium, Denmark, Finland, France, Germany, the Netherlands, Sweden). These differences cannot be explained by LTC needs. For instance, countries where over 25% of the population reports longstanding limitations in usual activities because of health problems

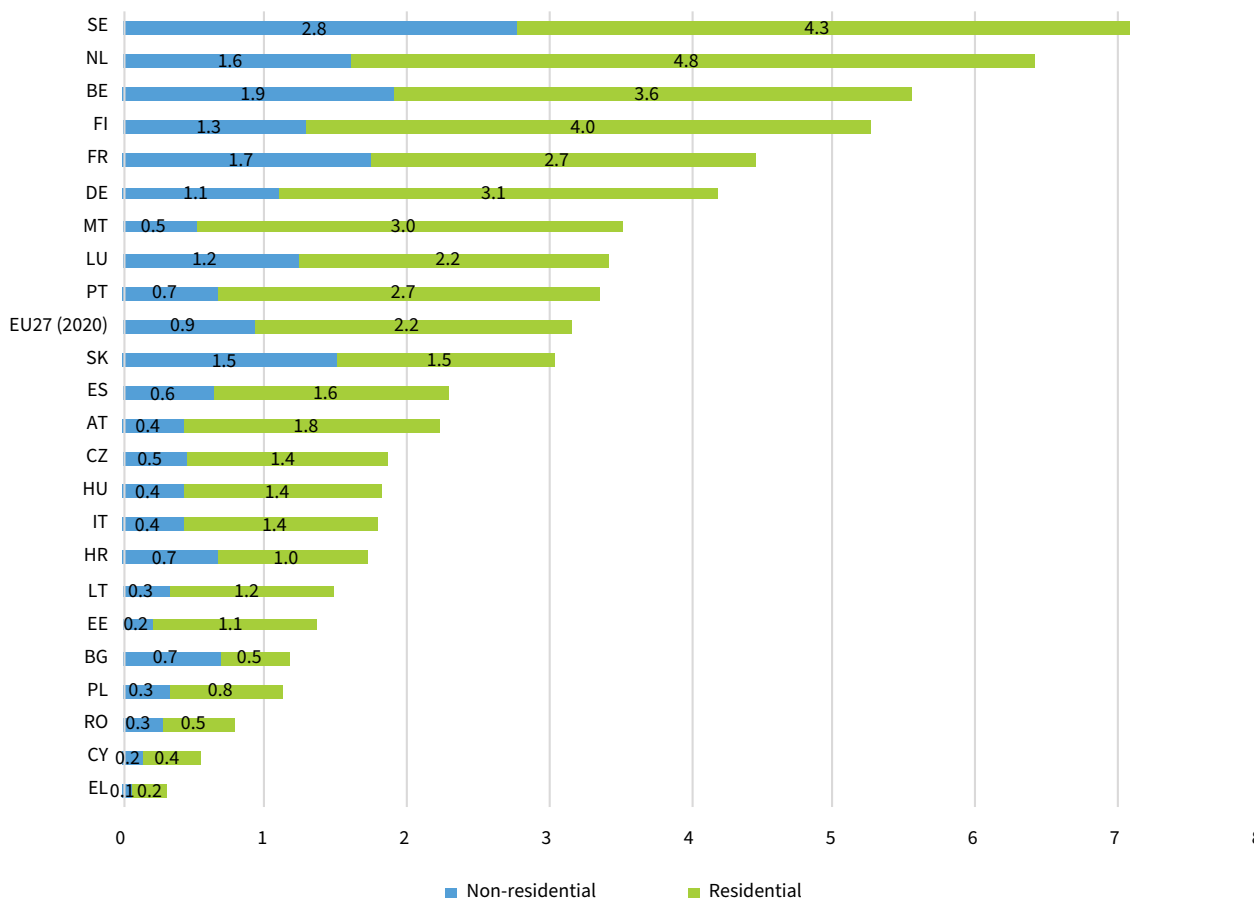
(2018) include both those with large LTC workforces (Finland, the Netherlands) and those with small LTC workforces (Estonia, Latvia). Among countries where less than 15% of the population reports such limitations, some have a large LTC workforce (Germany, Sweden) and some have a small LTC workforce (Bulgaria, Greece) (Eurostat [hlth\_silc\_06]). Differences in access to formal LTC are a more likely explanation for differences in workforce size (Eurofound, 2020).

Because of the low proportions of LTC workers in many countries, population survey data with limited sample sizes do not allow in-depth analysis for all Member States. However, the LFS data show that in Austria, Hungary, Italy, Malta and Portugal over 75% of the LTC workforce is employed in residential LTC (also in Estonia and Lithuania, but they have a relatively small LTC workforce as a share of the total workforce, at 1.4%<sup>4</sup> and 1.5%, respectively). In France, Luxembourg, Slovakia and Sweden, over 35% of the LTC workforce is employed in non-residential LTC; this is also the case in Bulgaria, Croatia and Romania, but they have a particularly small LTC workforce overall (at 1.2%, 1.7% and 0.8% of the total workforce, respectively).

<sup>3</sup> This figure treats 'not applicable' as not providing care and 'do not know' as missing values. If 'not applicable' were treated as a missing value, the estimate would be 41 million.

<sup>4</sup> Differences in the percentages in Figure 1 are due to rounding.

Figure 1: Long-term care workers as a share of the total workforce, by Member State, 2019 (%)



**Notes:** Annual averages of quarterly data. For some countries observations are missing and thus not all of the LTC workforce may be captured for certain age groups (Cyprus) or for the category NACE 88.1 (Denmark, Ireland, Latvia, Slovenia). The last four countries have been excluded.

**Source:** Eurofound analysis of EU-LFS data

The LTC workforce increased steadily from 4.7 million in 2009 to 5.6 million in 2014 and 6.3 million in 2019 (from 2.5% of the entire workforce in 2009 to 3.0% in 2014 and 3.2% in 2019). This is remarkable as the total workforce declined in the aftermath of the 2007–2008 global financial crisis. Some countries implemented staff freezes in LTC towards the end of the crisis, resulting in a delayed effect of the crisis (Eurofound, 2020). However, in the EU27 overall, the LTC workforce has continued to increase. Overall, within one decade, it has expanded by about one-third (33.5%) in size.

Overall, growth in employment in non-residential LTC has been larger than that in residential LTC. In 2019, of all LTC workers, 71% worked in residential LTC (down from 74% in 2009) and 29% worked in non-residential LTC (up from 26% in 2009). The EU27’s residential LTC workforce increased from 3.5 million in 2009 (1.8% of the entire workforce) to 4.5 million (2.2%) in 2019. In absolute numbers, growth

has been rather linear (with 4.0 million residential LTC workers in 2014), but as a proportion, the LTC workforce grew more rapidly up until 2014 (to 2.1%), as the overall workforce shrunk rather than grew. The non-residential LTC workforce increased from 1.2 million (0.6%) in 2009 to 1.6 million (0.8%) in 2014 and 1.9 million (0.9%) in 2019. Thus, while growth was steeper overall in non-residential LTC, it slowed more than that in residential LTC in the aftermath of the financial crisis. Part of the explanation for the slowdown may be that non-residential LTC workers are less likely to have a permanent contract or zero-hour contract (see chapter on ‘Nature of employment’) and were therefore easier targets of austerity measures (Eurofound, 2014).

These statistics mask a broad range of professions and services. Table 1 illustrates this in the case of Czechia with detailed data on the numbers and types of workers in the LTC sector by profession and setting.

Table 1: Long-term care staff composition in Czechia: full-time equivalent public LTC workers, by profession and service, 2018

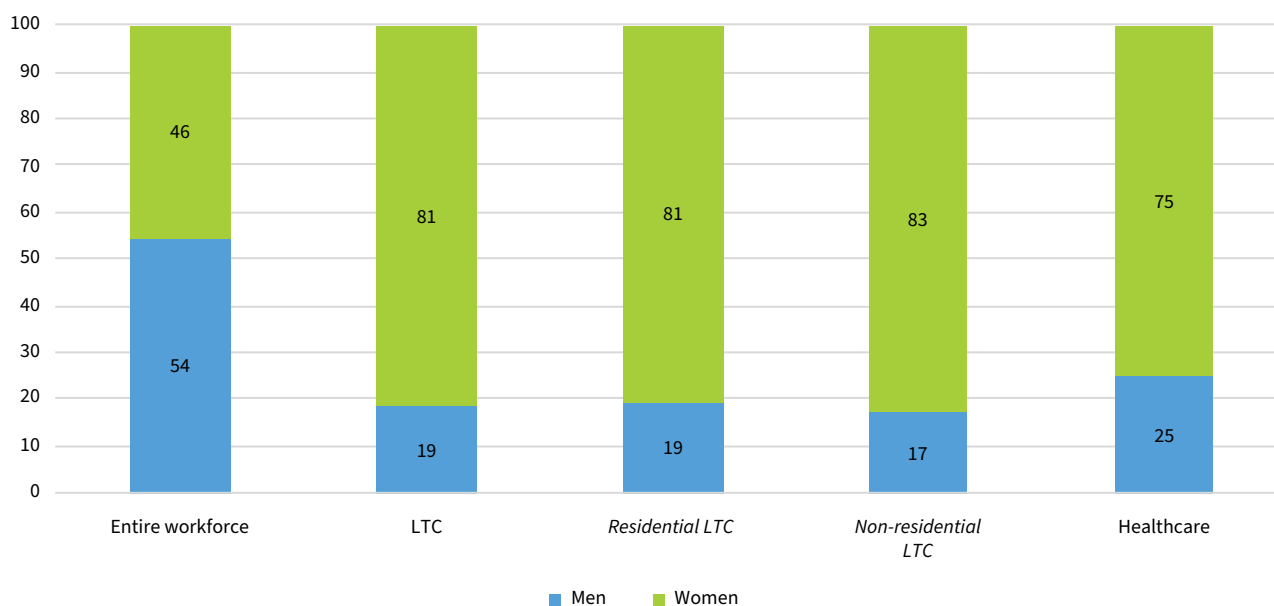
Type of service	LTC workers (total)	Selected care professions (total)	Selected care professions							
			Social workers	Social services workers	Doctors	General nurses	Carers and medical orderlies	Other health personnel	Tutors	Specialised educators
<b>Residential services</b>	<b>50,660</b>	<b>30,803</b>	<b>1,857</b>	<b>22,273</b>	<b>23</b>	<b>5,654</b>	<b>83</b>	<b>733</b>	<b>165</b>	<b>17</b>
Old people's homes	23,134	14,356	888	10,164	12	2,913	32	346	0	0
Special care homes	13,908	9,370	470	6,832	7	1,757	27	277	1	0
Homes for people with disabilities	10,809	5,680	294	4,244	3	929	20	87	89	14
Sheltered housing	2,140	1,074	178	873	0	11	0	4	8	1
Weekly care centres	669	323	27	160	1	44	4	19	67	2
<b>Field services</b>	<b>14,529</b>	<b>11,060</b>	<b>1,771</b>	<b>8,893</b>	<b>18</b>	<b>216</b>	<b>25</b>	<b>56</b>	<b>53</b>	<b>27</b>
Care services	7,053	5,751	535	5,192	0	20	0	4	0	0
Personal assistance	2,100	1,822	171	1,649	0	2	0	0	0	0
Respite services	1,811	1,297	129	936	13	174	24	17	3	1
Day-care centres	1,794	998	156	734	2	14	1	23	50	16
Professional social counselling	1,313	897	668	206	3	5	0	6	0	9
Social activation services for seniors and people with disabilities	349	210	93	114	0	1	0	2	0	1
Emergency care	109	85	19	62	0	0	0	4	0	0
<b>Total</b>	<b>65,189</b>	<b>41,863</b>	<b>3,628</b>	<b>31,166</b>	<b>41</b>	<b>5,870</b>	<b>108</b>	<b>789</b>	<b>218</b>	<b>44</b>

**Notes:** Average number of employees on the payroll and contract workers as established by regional authorities, 'statutory' (large) cities, municipalities and the Ministry of Labour and Social Affairs (organisations paying salaries).

**Source:** Ministry of Labour and Social Affairs, Czechia, 2018



Figure 2: Long-term care workforce by gender, compared with healthcare and the entire workforce, EU27 and the UK, 2019 (%)



**Note:** Annual averages of quarterly data.

**Source:** Eurofound analysis of LFS extraction provided by Eurostat

Considerable proportions of LTC workers may not be included in the statistics in this section. For instance, LTC workers whose entire work is undeclared are not covered by administrative data such as those in Table 1. While survey data may capture some undeclared workers, it may be very likely that they are excluded from the sample if they live with the care receiver. Results from the Network of Eurofound Correspondents confirm that, in several of the countries for which the proportion of LTC workers seems particularly low, undeclared domestic LTC appears to be more common (Greece, Italy and Spain). This can help to explain who is providing the necessary LTC in countries where there are low numbers of formal LTC workers but considerable LTC needs. Other explanations include low staff–user ratios, some LTC being provided by the healthcare sector (hospital beds) and, in particular, the large role of informal care provided by friends and relatives. Workers who are performing mandatory community service (usually instead of military service) in LTC are excluded from the LFS sample, but this is in line with the focus of this report, which excludes community, volunteer and informal LTC providers. LTC workers who reside in collective households (or institutions) are also excluded from the LFS sample.

## Female workforce

In 2019, around four-fifths (81%) of the EU’s LTC workforce was female and one-fifth (19%) was male (Figure 2). This has changed little over the past decade (82% female and 18% male in 2009). The gender imbalance is somewhat more pronounced in non-residential LTC (83% versus 17%) than in residential LTC (81% versus 19%).

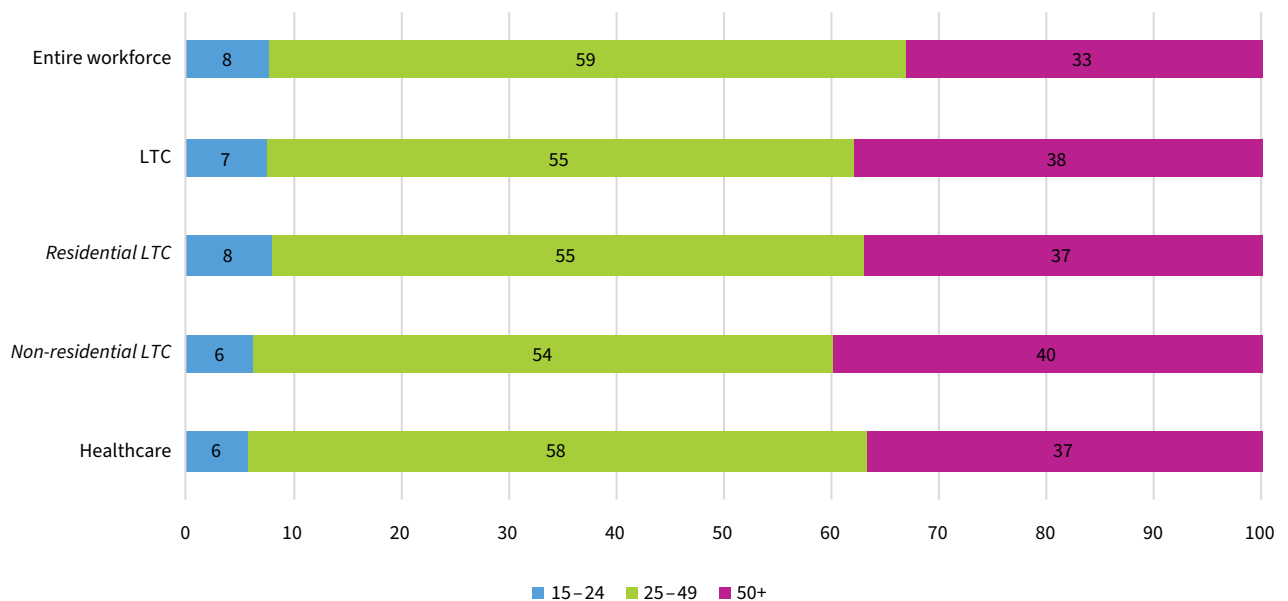
Input from the Network of Eurofound Correspondents confirms this gender imbalance. For instance, in Portugal, among 407 residential LTC nurses, 75% were female and 25% were male (Oliveira Neves et al, 2019). Domestic (and, in particular, live-in) care seems even more dominated by female workers. Of all 209 domestic care workers employed in Malta in September 2019, 87% were female, and 13% male. In Austria, 95% of live-in carers are female and 5% are male. In Spain, 91% of home-based personal care workers are female, and 9% are male (Mercader Uguina et al, 2020).

## Older workforce

The share of workers aged 50 years or over in LTC is 4.7 percentage points above that in the entire workforce: 37.9% versus 33.2% (Figure 3). It has also increased faster over the past decade, by 9.8 percentage points (from 28.1% in 2009) compared with 7.3 percentage points for the entire workforce (from 25.9% in 2009). This applies to a larger extent to non-residential LTC (39.8% share for those aged 50+ years and a 10.1 percentage point increase) than to residential LTC (37.1% share for those aged 50+ years and a 9.6 percentage point increase).

Interestingly, the proportion of 15- to 24-year-olds working in LTC is only 0.3 percentage points below that in the workforce overall (7.5% versus 7.8%, respectively) and is higher than that in healthcare (5.7%). This can be interpreted as a positive finding, although younger people may also be more likely to leave the sector. The middle-aged group (25–49 years) is particularly underrepresented in LTC (54.6% compared to 59.0% overall and 57.6% in healthcare).

**Figure 3: Long-term care workforce by age group, compared with healthcare and the entire workforce, EU27 and the UK, 2019 (%)**



**Note:** Annual averages of quarterly data.

**Source:** Eurofound analysis of LFS extraction provided by Eurostat

Country-level data that emerged from the Network of Eurofound Correspondents confirm this picture. For instance, in Lithuania, 57% of workers in municipal, non-governmental organisation (NGO) and private home help services providing services for older people are aged 50 years or older, compared with 31% of the total workforce (Žalimienė et al, 2017). In Ireland, 38.7% of ‘patient and client care’ workers (including the most common LTC profession, ‘healthcare assistants’) are aged 55 years or older, compared with 24.3% of workers in the healthcare and LTC sectors jointly (2018).

## Migrants and mobile citizens

In 2019, 7.9% of the EU’s LTC workforce was made up of foreign workers, with more workers from outside (4.5%) than within (3.4%) the EU (LFS). These rates are close to those for the overall workforce, with 8.0% of foreign workers (4.5% non-EU; 3.5% EU), but are in contrast to those for healthcare, which has fewer foreign workers overall (4.8%) and particularly non-EU migrant workers (2.4%). This difference may partly be the result of the more stringent training requirements for healthcare workers, as well as the lack of recognition of foreign diplomas forming a larger barrier to work in healthcare, in particular for non-EU migrants.

Malta (43%), Luxembourg (21%), Ireland (19%) and Austria (14%) have the highest share of foreign workers in the LTC sector, followed by the UK (13%), Cyprus, Germany, Italy, Norway (all 12%) and Sweden (11%) (LFS, 2019). Belgium (10%) and Spain (9%) also have above-average rates of foreign workers. On the other hand, several Member States have virtually no migrants or mobile citizens working in LTC: Bulgaria, Croatia, Hungary, Lithuania, Poland, Portugal, Romania and Slovakia (all 1% or below).

The composition of the foreign workforce differs by country. In the four countries with the largest share of foreign workers, two have a considerable share of non-EU migrant workers (Ireland and Malta), while two do not (Austria and Luxembourg). In Ireland, 61% of the non-Irish LTC workforce are migrants, while 39% are from the EU. In Malta, 46% of foreign LTC workers are migrants, while 54% are mobile citizens from the EU. In contrast, only about 1 in 20 foreign LTC workers are migrants in Austria (5%) and Luxembourg (4%), while most are from the EU (95% and 96%, respectively).

Recent statistics from the national sources broadly validate these findings and provide further details, even though the data on LTC are often mixed up with data for other social services and healthcare. Recent statistics show the proportion of foreign workers in LTC to be 17% in England (adult social care); 11% in Germany (elderly care) (Isfort et al, 2018); 7% and 16% in Belgium’s Flemish and Walloon regions, respectively; and 5.7% in the Netherlands (healthcare and welfare overall). In Sweden, 28% of elderly care workers are foreign-born. In Germany, 44% of foreign workers in the health and care sector in 2015 were from other EU Member States, with 20% from Poland (Rada, 2016). In Ireland, the majority of public sector workers in home help services are Irish nationals; private residential LTC is considered to rely more on migrant workers. LTC jobs created by the expanding residential LTC sector and subsidies for home care in Malta have largely been filled with migrant workers. The Network for Eurofound Correspondents’ input confirmed that there are almost no foreign LTC workers in some eastern Member States from which people move to work in LTC in other countries, including people with nursing qualifications. However, Croatia, Czechia and Slovenia do have some LTC workers from neighbouring countries, and immigrant labour is

emerging in other countries in domestic help and care, for example Ukrainian workers in Poland.

In Germany, the number of foreign workers in LTC increased by 28% from 2012 to 2015 (Rada, 2016). In Denmark, the number of foreign nationals working in social care and healthcare has risen faster than in the labour market on average and more than doubled between 2008 and 2018. In the Netherlands, the absolute number of non-nationals working in the healthcare and welfare sector decreased between 2010 and 2017, even though reforms in the sector have led to an increase in recruitment. In England, the proportion of non-British nationals in the adult social care sector was relatively stable between 2012 and 2019, at 17% (covering workers employed by local authorities and the independent sector, but not those employed by households or direct payment recipients). Over the same period, the proportion of EU (non-UK) citizens in the workforce *increased* by three percentage points and that of non-EU citizens *decreased* by three percentage points, reaching 8% (115,000 jobs) and 9% (134,000 jobs), respectively, in 2019. Romanian (13% of non-UK citizens in the workforce) and Polish (11%) workers were the two most common non-UK nationalities employed in the sector (Skills for Care, 2019). Among registered nurses, the proportion of foreign workers is considerably higher, at 36% in 2019 (although it has decreased slightly, from 40% in 2013, and the proportion of EU nationals among the non-British workers has increased, possibly because of the increase in immigration and skills requirements for nurses educated outside the European Economic Area).

In several Member States, foreign labour is common in the domestic care subsector, with the employer being the LTC user, even though in Italy, for example, the share of Italian nationals who are domestic care workers in their own country has increased. In Italy, three-quarters of the total of 402,413 carers (*badanti*) employed by private households are foreign nationals, of whom over 70% are from eastern Europe (both EU and non-EU), with 8% from Latin America and 5% from North Africa (2018 data from INPS, 2019). In Spain, in 2017, 63% of those employed in domestic help and care were foreign nationals (based on the EPA (Encuesta de Población Activa), a Spanish survey of the economically active population). Based on 2008 and 2017 (EPA) data, there was a decrease in the number of foreigners working as domestic helpers, but an increase in foreign workers providing care in households (61,000–69,000; Díaz Gorfinkiel and Martínez-Buján, 2018).

In a number of Member States, some care subsectors are nearly entirely based on foreign labour, such as domestic help, in particular live-in care (for example, Austria, Cyprus, Greece, Italy, Malta, the Netherlands, Spain – see section on ‘Live-in care’). The qualification profiles needed and labour market entry requirements differ between countries, and, together with the demand in the formal

and undeclared labour markets, could explain some of the patterns seen. In several countries, there appears to be an overrepresentation of foreign workers in residential LTC or in home care provision by the private sector, including in private households; in social care, the proportion of migrant workers is smaller. This is the case in Denmark and Ireland. In Spain, foreign workers are concentrated more in domestic care, whereas the proportion of nationals is higher in public home and residential LTC. In Finland, 2–5% of ‘practical nurses’ are foreign nationals (2012–2015), mostly from neighbouring countries (Estonia, Russia, Sweden); there is no particular overrepresentation of foreigners in LTC (although there are no precise data).

These differences in migrant worker share between the LTC subsectors may be related to qualification requirements, including language fluency and knowledge of services and regulations. The different skills needed for particular LTC jobs may provide some explanation, with carer roles that involve social interaction and mediation with services filled more by nationals (Finland, Ireland), and shortages of workers required for helping tasks met using migrant and mobile workers (Ireland). The considerable undeclared LTC labour markets (Greece, Italy, Spain), with no formal skills/qualifications barriers for entering work and a cost advantage for users (untaxed labour), skew the LTC workforce composition towards foreign labour. Because of its informality and high demand, domestic care can be an entry pathway for migrant workers, enabling them to subsequently find a better job in the host country (this has been noted in Spain, for example).

Attracting foreign workers to address shortages in the LTC workforce has featured in public or policy discourse in those countries that already have a substantial share of foreigners working in LTC (such as Austria and Sweden), as well as in those that have a well-developed care sector but do not currently have many foreign workers (such as Finland). Skill drain can also be a factor; for example, in Portugal, where substantial emigration of nurses has had an impact on LTC provision, ideas for attracting migrant workers in certain occupations have been proposed by Portugal’s national LTC association (ANCC). In some low-wage labour-sending Member States, where the presence of migrant workers in LTC is less notable or there is no supply or demand, immigration as a solution to LTC provision either is not debated or is less prominent.

## Staff turnover

Employee turnover refers to the number of workers who leave an organisation. For any year, the turnover rate is usually calculated by dividing this (annual) number by the total number of employees on average that year. Turnover increases the costs of care provision and compromises its continuity and quality. Turnover national data were identified for the entire LTC sector only for the Netherlands (Table 2).

**Table 2: Staff turnover rates, LTC, the Netherlands (%)**

	2016–2018
<b>LTC</b>	<b>10.5</b>
– Residential LTC	9.4
– Non-residential LTC	12.3

Source: AZW StatLine (undated)

In other countries, studies and surveys provide various estimates of turnover:

- **Austria:** Three out of four health and care workers have considered leaving their profession (AK Wien, 2019).
- **Finland:** 70% of practical nurses have occasionally considered changing professions (SuPer, 2016).
- **Germany:** On average, in 2014, each LTC employer experienced 2.27 departures of qualified nursing staff. In home care, 54% of employers reported that the turnover rate is declining. Usually, employees look for a new employer within the same sector; few go to work in a hospital or for a health insurance company or become self-employed (Deutsches Institut für angewandte Pflegeforschung, 2016).
- **Portugal:** The turnover rates for nurses in residential LTC units were 36% in medium-term care and rehabilitation units, 24% in long-term (over 90 days) care units for people with chronic disabilities or diseases and 17% in convalescence units (Oliveira Neves et al, 2019).
- **Sweden:** In total, 4 out of 10 LTC nurses and nursing assistants regret their choice of profession because of the conditions of the job, low wages and underemployment. Over half have considered changing jobs during the past year because of their work situation (Kommunal, 2018a).
- **UK (England):** The turnover rate for directly employed adult social care workers was 30.8% in 2018/2019, with about 440,000 leavers reported over the course of the year (Skills for Care, 2019). Many remain within the sector: two-thirds of recruitment occurs within the adult social care sector. The turnover rate is higher for registered nurses (34.0%), care workers (39.5%) and, in particular, domiciliary care workers (43.7%). Turnover rates increased by 9.1 percentage points between 2012/2013 and 2018/2019. Turnover is higher for new care workers, with nearly half (48%) of care workers leaving within a year of starting (Communities and Local Government Committee, 2017). Among care workers, 49% have thought about leaving their job (UNISON, 2018). Turnover rates of those working in

direct care are nearly three times higher in the private for-profit sector than in local authorities (36% and 12.5%, respectively) (Skills for Care, 2018).

Despite the absence of data, experts in some countries argue that turnover is high (and that it is difficult to find staff – see section on ‘Staff shortages’). They attribute these high rates to the stressful nature of the work and low wages (Estonia); the low wages together with demand for (even unqualified) carers abroad, where they receive higher pay (Bulgaria); the job of personal assistant being carried out by students or people who consider it to be temporary (Finland); and people moving to jobs in hospitals (Luxembourg). In contrast, in Croatia, it was argued that the turnover of LTC employees is low, particularly in private providers, where most of the employees work for over 20 years.

## Staff shortages

### Estimates of expected shortages

Broadly, when analysing staff shortages, one can distinguish between countries with:

- 1) limited access to LTC, requiring few staff, with relatively small increases in staff shortages expected regardless of ageing unless access to LTC is improved. These countries have a lower gross domestic product (GDP) (Eurofound, 2019a). They have little scope to compete with higher-wage countries for staff.
- 2) better access to LTC, requiring more staff, and often with immediate challenges in filling vacancies; staff shortages will be likely to increase because of the ageing of society (and the LTC workforce).

Except for some Member States in the first group, all Member States report unfilled vacancies; anticipate that there will be an increased need for personnel; or discuss expected staff shortages in general terms. However, even in countries where national reports suggest that LTC staff shortages will increase, no estimates of staff shortages were identified (Greece, Latvia, Lithuania, Sweden); estimates of shortages (i.e. joining demand and supply estimates) in LTC were identified only for Poland. Most available estimates focus on the demand side only: LTC or staff needs (Table 3). These estimates focus on care jobs in the LTC sector, especially nursing and (social/personal) care.

Estimates of LTC staff needs usually relate to full-time equivalent (FTE) jobs. As many in the sector work part time, larger numbers of staff are needed to fill these gaps. For instance, in Austria, assuming constant part-time rates, the estimated need for 14,200–16,000 additional FTE LTC workers in 2030 translates into 18,700–21,500 workers in total (Rappold and Juraszovich, 2019).

Table 3: Projections of LTC staff shortages or increases in staff/care demand/needs

Country	Base year	Year	Estimate	Source
<b>Shortages (unfilled vacancies)</b>				
PL	2010	2030	Residential LTC: 11,010–16,439 FTE Home care: 5,790–10,178 (1.9–2.9% of those working in LTC; higher than in healthcare)	Golinowska et al (2014)
<b>Increase in staff needs (excluding replacement needs, for example because of retirement)</b>				
AT*	2017	2030	Scenario 1 (demographics only): 32% (an increase of 14,200 FTE) Scenario 2 (including expansion of home care): 36% (an increase of 16,000 FTE)	Rappold and Juraszovich (2019)
	2016	2030 2050	39% (an increase of 18,000 FTE) 127% (an increase of 58,000 FTE)	Famira-Mühlberger and Firgo (2019)
CY	2015	2027	12% (an increase of 176)	HRDA (2017)
CZ	2017	2030	65% (an increase of 45,292 FTE)	Horecký and Průša (2019)
		2035	97% (an increase of 68,271 FTE)	
		2050	160% (an increase of 112,219 FTE)	
DE	2015	2035	44% (an increase of 150,209)	Flake et al (2018)
FI	2018	2030	60% (30,000 FTE)	Finnish Government (2020)
FR	2018	2030	150,000–200,000 FTE	Ministry of Social Affairs and Health (2019a)
IT	2018	2030	LTC domestic carers: 15% (60,487)	DOMINA (2019)
		2055	LTC domestic carers: 70% (282,587)	
<b>Increase in demand/needs</b>				
IE	2015	2030	Residential LTC: 40% (to 40,000 beds) Home help package (public and private): 57% (to over 100,000 users)	Wren et al (2017)
	2016	2031	Public residential LTC ('fair deal scheme'): 95% (to 45,906 users)	
IT	2015	2030	People who need help with: - at least one IADL: men 34% (0.4 million), women 21% (0.6 million); - at least one ADL: men 37% (0.15 million), women 23% (0.25 million).	Buratta (2018)
PT	2015	2025	Residential LTC: 20% (to 17,597 beds)	ERS (2015)

**Notes:** Projections for 2030 and/or 2035 and for the final year projected are provided if available; otherwise, projections are provided for the years available. Only projections specific to LTC and using base data from 2010 or later are included. \*(Slightly) diverging employee numbers between the two studies relate to the different annual data used (2016 and 2017) and to additional data provided by regional states used in Rappold and Juraszovich (2019). ADL = activities of daily living; IADL = instrumental activities of daily living.

Shortages occur unevenly within Member States and different types of LTC. In Finland, shortages are concentrated in the north and east. In France, recruitment difficulties affect all parts of the country, but especially the border areas with Luxembourg and Switzerland (Pôle emploi, 2020), mainly because of the higher wages in those countries. In Luxembourg, recruitment is more difficult in the northern regions because of the low population density and travel time required. Border workers do little to alleviate this problem as most work in Luxembourg's densely populated areas bordering the French regions in which they reside. In Lithuania, over half (34 out of 60) of municipalities report a shortage of nursing professionals and five report an oversupply (2017). In Spain, each LTC professional is, on average, in charge of 109 nursing home beds (private and public); however, this figure can be double in some regions, such as Madrid (261), Castilla y León (225) and Extremadura (204) (El Diario, 2019). In Denmark, in 2017, 73% of municipalities reported shortages in elderly care (49% in healthcare) (FAO and KL, 2017). For 'social and health assistants', there was a lack of labour in 2007–2010, followed by no shortages in 2011–2014 and then a progressive increase in shortages in 2014–2017. For 'social and healthcare workers', after a labour shortage in 2007–2010, demand and supply became more balanced, with shortages present only in certain localities (including Copenhagen). In Romania, among 116 providers of elderly care (95 residential, 21 home care), 37.5% had vacancies, with a higher proportion of vacancies in residential centres (15% of home care services, 50% of residential centres). Shortages were most apparent in rural areas (Matei and Ghenta, 2018) and in smaller cities (Romanian Government, 2018). These patterns tend to be similar in healthcare.

The shortages are often of skilled care personnel, in particular nurses. In Austria, the current shortage of 5–10% of the workforce is concentrated in high-skilled occupations (certified nurses). In Germany, in 2018, there were 19 unemployed geriatric carers per 100 vacancies, so even if all of these unemployed individuals were matched with a vacancy, unfilled vacancies would remain. In contrast, there were 322 unemployed geriatric care aides per 100 vacancies, indicating no shortage in this area. In Portugal, there are particular shortages among nurses specialising in areas such as rehabilitation (Jornal Enfermeiro, 2015). Estonia anticipates the largest increase in need for 'care workers' in its social work sector: from 2,060 in 2016 to 2,735 in 2021 (OSKA, 2020). The lack of personnel is most apparent in relation to therapists (physiotherapists, speech therapists and activity therapists) and nurses, mainly in home care (Rasu, 2016). In Romania, there are mainly shortages of nurses, social workers, psychologists and family physicians. Professional education and training of specialised staff usually takes place in large cities, and smaller towns and villages experience serious difficulties in finding qualified staff (Bulgaria, Romania). In the Flanders region of Belgium, there are particular shortages among skilled nurses.

LTC professions sometimes appear on lists of occupations for which there are shortages or for which shortages are expected (Austria, Belgium, Slovakia). For instance, the Slovak list includes carers in residential LTC facilities (in

the regions of Bratislava and Kosice). LTC professions also feature on lists of occupations with the highest employment rates; for example, in Spain, home care workers are ranked 24th and residential LTC workers are ranked 27th in terms of employment rates. In France, home helps, care assistants and nurses are among the five professions for which most jobs will be created by 2022 (France Stratégie and DARES, 2015).

Data on open vacancies are not always easy to interpret. Vacancies are not filled instantly because of the time taken to search for candidates and undertake the selection procedures. Vacancy data can fluctuate a great deal over a short time period, making it hard to draw conclusions. However, vacancy data can reveal staff shortages if vacancy numbers are particularly large, there has been a clear longer-term increase in vacancies or there are reports that vacancies are difficult to fill. In Lithuania, vacancies in LTC increased by over 500% from 2005 (415) to 2019 (2,177). Open vacancies in social services have been increasing since 2015 in Flanders and rose sharply (by 13.7%) in 2019 (the increase was even greater in healthcare: 15.5%). Flanders publishes a 'tension' indicator that describes the average number of non-working jobseekers in the last 12 months as a ratio of the average number of vacancies in the same period. If the indicator is high, it is easier to fill vacancies. For LTC, the indicator has decreased steadily since 2015, the year when it became available. It is above 1 (1.33 in 2020), but lower than in all sectors jointly (3.74). However, the indicator is particularly low (and has decreased steadily) for high-skilled nurses (0.35). In Finland, between January 2019 and June 2019, the number of open vacancies for practical nurses (who care for people with illnesses or disabilities) was 6,691, while on average 5,525 practical nurses were unemployed or temporarily laid off (Ammattibarometri, 2020). Between 2006 (the earliest available data) and 2018 (the latest available data), unfilled positions in LTC were lowest in 2014 (33,000) and highest in 2018 (55,000). The large number of unemployed practical nurses despite the staff shortages can be partly explained by municipalities avoiding hiring permanent workers as reforms are being discussed to transfer responsibility of social services to regions and also by the issue of fixed term contracts and financial issues (Yle, 2015). In France, in 2015, nearly half (49%) of residential care facilities reported difficulties in recruiting staff who have direct contact with older people with loss of autonomy. Of the facilities that reported difficulties, 63% had at least one position remaining unfilled for six months or more. In France, EHPADs (*Établissement d'hébergement pour personnes âgées dépendantes*) are the most widespread type of residential LTC for senior citizens, and also offer LTC for people with more advanced needs. About 40% are publicly owned, 30% are private for-profit and 30% are private non-profit establishments. Private for-profit EHPADs report the most difficulties with regard to staff shortages. Among all EHPADs, 10% reported an unfilled position of coordinating physician for more than six months and 9% reported an unfilled position of care assistant for more than six months (16% in the private for-profit sector). In 2017, there was an immediate need for around 17,000 home care workers (Ministry of Social Affairs and Health, 2019a). Along



with a sharp rise in the number of recruitment projects (open positions for which an employer is looking for an employee) (from 53,400 in 2016 to 86,300 in 2020), the proportion of projects experiencing difficulties has also increased. For 2020, according to the public employment service (Pôle emploi), 79.5% of recruitment projects for home care and domestic help were expected by employers to be difficult. Between 2013 and 2016 these rates ranged between 60% and 65%. The rate is somewhat lower for caregivers (61.8%) and, in particular, nurses (48.9%). It is broadly acknowledged that recruitment difficulties in LTC have worsened over the past few years (Ministry of Social Affairs and Health, 2019a).

It is difficult to interpret waiting times in terms of staff shortages as there may be many different reasons for waiting lists (Eurofound, 2020). One reason is lack of funding (long waiting lists in specialised care homes in Romania), which can be closely linked to staff shortages. However, there are also other reasons. For instance, people may prefer a certain residential LTC home, resulting in a waiting list, even though there are other homes with no waiting lists, or waiting lists may be particularly long because people are listed long before their needs arise. However, in some countries waiting lists have been particularly attributed to staff shortages (Lithuania: Tamutienė and Naujanienė, 2013; Kuznecovienė and Naujanienė, 2015; Malta: *Times of Malta*, 2018; Slovenia: IRSSV, 2019). Staff shortages in Malta are partly to blame for a lack of take-up of subsidies for hiring home care staff (along with a lack of awareness of the scheme) (*Times of Malta*, 2018).

In the aftermath of the 2007–2008 global financial crisis, several countries froze public service hiring, including in the LTC sector, leading to waiting lists because of understaffing, while potential LTC workers were left unemployed or inactive. In Slovenia, no new or replacement hiring took place in the public sector as a result of the austerity measures introduced in the aftermath of the crisis. This led to waiting lists and unemployment among nurses. Ireland, experienced a rapid change from shortages because of recruitment embargoes (roughly 2008–2016) to difficulties finding staff once embargoes were lifted.

Sometimes, information about current staff shortages comes from comparing actual staff–user ratios (see section on ‘Work intensity and environment’) with those set in guidelines. In Bulgaria, according to guidelines on the structure and number of social services staff required for both residential and non-residential LTC, the minimum number of social services staff required for adults is 9,900, compared with an actual number of about 8,500 (late 2019). The challenge with this approach to measuring staff shortages is that the mandated minimum staff ratio may be low.

Data often include other sectors (most notably healthcare), without a breakdown for LTC. In 2019, the Irish Nurses and Midwives Organisation (INMO) reported 420 unfilled vacancies in community health organisations in the Irish public health system (including public LTC facilities). In Hungary, 4.2% of jobs in the social and healthcare sectors

were vacant in the fourth quarter of 2019, the highest of all sectors. This was followed by administrative and service support activities, at 3.3%, with a national average overall of 2.3% (Hungarian Central Statistical Office quarterly vacancy data). In Finland, an estimated 283,000 new positions will open in the social and healthcare sector by 2030 (Ministry of Economic Affairs and Employment, 2015a). In Italy, between 2019 and 2023 the need for workers in residential and non-residential LTC, social work, healthcare and veterinary services (NACE codes 87 and 88, 86 and 75) has been estimated at 360,000–380,000, of which one-third should cater for additional needs and two-thirds for replacement of staff (Unioncamere, 2019). In Flanders, an estimated 46,000 new employees will be needed in ‘health and social care’ every year until 2026. In Denmark, in 2018, the occupation of ‘social and health assistant’ was among the top five occupations with unfilled vacancies (576 positions). In the Netherlands, there will be an estimated 80,000 unfilled vacancies in health and care in 2022 (CBS, 2019).

Estimates often do not include all LTC workers, with domestic LTC workers, in particular, often being excluded.

### Factors impacting on shortages

Estimates of future staff shortages and LTC needs are sensitive to assumptions (Saltman et al, 2006). For instance, 2018 estimates of health and care sector shortages in the Netherlands in 2022 had to be adjusted downward in 2019 by over 20%, partly due to the increased number of entrants to the sector, people returning to work in LTC and nursing students (including many older students who switched careers). The COVID-19 crisis is also likely to have an impact on such estimates. Factors influencing staff shortages can be specific to individual countries; for instance, in some countries a significant number of people perform LTC work as an alternative to military service (Austria). However, general factors influencing staff shortages include the following care service (demand) and workplace/workforce (supply) dynamics.

#### Care service (demand) dynamics

- **The population’s age profile and LTC needs, and assumptions on how they will develop:** Estimates of the age composition of the population are regularly, and sometimes substantially, adjusted (Saltman et al, 2006). Furthermore, in estimating future LTC needs, it is often assumed that a fixed proportion of the population above a certain age has LTC needs (estimates from France, Ireland, Italy (DOMINA, 2019), Latvia and Poland). The Polish estimate assumes that the share of beneficiaries in each age group remains the same as in the base year (2010). However, health and disability rates change over time. Occasionally, estimates consider that LTC needs of specific age groups may decrease (Portugal (ERS, 2015); SOME model used by the Finnish Ministry of Social Affairs and Health, 2017). For example, in Italy, the estimate of 2.5 million older people with activities of daily living (ADL) needs in 2050 is reduced to 1.7 million if the trend of improved health is considered (Buratta, 2018). Regardless of assuming fixed or varying needs



by age, using the population's age composition for international comparisons of LTC needs is a challenge, as the prevalence of health problems and disability differs among people aged 65 years or more across Member States. Besides fertility, health and mortality, a population's LTC needs also depend on fluctuations in migration. The estimate for Luxembourg considers changes in migration, but not border workers, who are expected to constitute an increasing share of LTC users.

- **Access to quality LTC:** Many people in the EU have unmet LTC needs (Eurofound, 2020). Addressing these needs often requires more staff. For instance, despite a 24% increase in its residential LTC workforce, from 21,000 in 2010 to 26,000 in 2018, Slovakia still faces staff shortages, partly because of increased access to LTC. In Italy, in 2016, an estimated 3 million people did not receive the LTC they needed (Fosti and Notarnicola, 2019). It has been argued that Spain needs 125,000 more nurses to provide LTC to the same standard as that in Member States with similar economies (COEH, 2019). In Czechia, 18,789 of the projected increase in the number of staff needed by 2035 (Table 3) is related to expected policy changes (for example, increasing diagnoses, addressing insufficient capacity in some regions). In Luxembourg, LTC beneficiaries tripled from 5,000 in 2011 to 14,209 in 2018, mainly because of increased access to (and awareness of) entitlements and the increased needs of the ageing population.
  - **Availability of informal care:** A reduction in the availability of informal care may occur as a result of emigration (Romania), increased employment levels, changing societal norms and a reduction in the number of children per household. While there is no sign yet of reduced informal care provision (Eurofound, 2019a), this may change.
  - **Types of LTC services offered and demanded:** Deinstitutionalisation impacts on the type of care needed. If institutional care is replaced by home care systems, staff needs (and shortages) in institutions decrease, but increase in home care (Estonia). In Lithuania, staff vacancies in non-residential LTC increased from 324 in 2012 to 481 in 2013 and 563 in 2019, partly because of the launch of the Integrated Help at Home Development Programme, which increased access to social care and nursing services at home (residential LTC staff vacancies increased from 659 in 2012 to 872 in 2013, followed by a decrease to 661 in 2019). Of the 14 types of LTC services in Czechia, staff needs are expected to decrease over the next few decades only in homes for people with disabilities. Few estimates distinguish between types of LTC needs. The Italian estimate is an exception in distinguishing between activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. The number of people with at least one IADL is projected to increase from around 4 million to around 5 million between 2015 and 2035; the number of people with at least one ADL is expected to rise from 1.5 to 1.9 million during the same period. The estimate is further differentiated by gender: many more women than men have these care needs, but the increase is larger among men (Table 3).
- Workplace/workforce (supply) dynamics**
- **Ageing of the LTC workforce and pension policies:** In Flanders, 52,000 health and social care workers are expected to retire by 2026. In France, in 2019, it was reported that 350,000 posts need to be filled between 2019 and 2025: about 92,000 new posts, 60,000 unfilled posts, and 198,000 posts that have to be renewed because of retirement and turnover (Ministry of Social Affairs and Health, 2019b). In Finland, between 2020 and 2029 the proportion of employees who will retire is similar to the average for the public sector (33%) for some LTC professions (for example, personal care assistants, 33%), but higher for others (for example, charge nurses, 49%) (Keva, 2019). Retirement policies are an important factor in determining the impact of ageing workforces on staff shortages. Interestingly, in residential LTC, the proportion of workers aged 65 years or older in the EU is relatively high and has nearly doubled in the past decade, from 2.2% (2009) to 4.3% (2019), compared with 1.7% and 2.5%, respectively, for the workforce as a whole (LFS). This increase may indicate that changes have been made to facilitate working beyond the statutory retirement age (Eurofound, 2012).
  - **Productivity and technologies:** Some predictions assume increases in productivity (Ministry of Economic Affairs and Employment, 2015b), including through improvements in technology (the estimate for unfilled vacancies in health and care in the Netherlands mentioned above assumes some robotisation). There can be trade-offs between quality of LTC and productivity, for instance relating to the time that carers spend with users.
  - **Capacity/staff–user ratios:** In Finland, in order to meet a higher proposed staff–user ratio, 4,000–5,000 additional nurses will be needed by 2023. In France, the number of people working in the field of loss of autonomy in old age is expected to increase by about 20% by 2030, or by around 30% if additional policy measures, including increased staff–user ratios, are implemented (Ministry of Social Affairs and Health, 2019a).
  - **Absenteeism:** In the Netherlands, absenteeism in LTC increased in the third quarter of 2018 in comparison with the 12 previous months, from 4.9% to 5.1%, leading to higher staff needs. COVID-19 may have a long-term impact, with staff taking sick leave more often when experiencing flu-like symptoms.
  - **Competition for staff with other sectors:** In Flanders, decreased unemployment in the region overall has led to staff shortages, with more attractive employment opportunities available elsewhere. In terms of skilled workers (mostly nurses), LTC competes especially with healthcare, and so policies affecting work in one of these sectors affect work in the other sector.

- **Migrant/mobile workers:** Staff shortage projections rely on assumptions about migration policies; if it is administratively easy to employ foreign workers (for example, foreign diplomas are recognised), there are few language barriers and society is open to workers from abroad, shortages are less likely. For sending countries, outflux contributes to shortages. For instance, after Croatia joined the EU (2013), many nurses left for other Member States. The shortage of nurses in the LTC sector is estimated to be above 1,000 (tportal.hr, 2019).
- **Education:** In Flanders, from 2016 to 2018, applications for a bachelor's degree in nursing decreased by one-quarter, to 7,300. The trajectory through secondary education (for lower skilled nurses) showed a smaller decrease. Furthermore, because of a reform in tertiary education for nurses, the programme was lengthened and in 2019 no new nurses graduated, with a spike in unfilled vacancies. In Sweden, the estimated shortage in LTC workers with a vocational education was just over 2,000 in 2017 and is projected to increase to 56,000 in 2025 and 143,000 in 2035 (Kommunal, 2018b). To maintain the current number of nurses in Lithuania, an estimated 500

students should be admitted yearly to nursing studies. However, graduates may decide to work abroad or in other fields, or go on to further study, resulting in an oversupply of certain grades (Grigaliūnienė, 2011). In France, between 2012 and 2017, there was a 25% decrease in entrance exam applications to training institutes for nurses' assistants (*Instituts de Formation d'Aides-Soignants*, IFAS). Geriatrics is the second least popular speciality for students entering the third cycle of medical studies. For the civil service alone, only 129 of the 370 hospital practitioner posts put out to tender in geriatrics in 2017 were filled (Ministry of Social Affairs and Health, 2019a). In 2018, 22,800 students graduated as nurses' aides, 300 fewer than in 2017. The number of graduates increased sharply from 2000 to 2005 (+58%) following an increase in training capacity (24,700 registered in training in 2010 compared with 12,300 in 2000). After a period of more modest increases, the number of enrolments in training is falling (-6% between 2016 and 2018), with the annual number of candidates taking the selection tests for entry into training as a care assistant falling even more: from 111,100 in 2014 to 64,500 in 2018 (-42%) (DREES, 2019).

## 2 Nature of employment

This chapter discusses the ‘nature’ of employment in LTC: whether LTC workers are privately or publicly employed, their types of contracts and the role of self-employment. It also discusses the role of zero-hour contracts, platform work and undeclared work. Finally, it highlights a type of employment specific to the LTC sector, where precarious forms of employment are relatively common: live-in care. These forms of employment may capture some of the ‘other type of contracts’, which are found more frequently in LTC (11%) than in healthcare (5%) and all sectors together (9%). These workers do not see themselves as self-employed. Nor do they have a permanent, fixed-term, temporary employment agency or training scheme contract (EWCS 2015).

### Public versus private sector employment

Differences between public and private sector employment emerge throughout this report, so it is a relevant dimension of the nature of employment to highlight (for example, see the section on ‘Earnings’ and the chapter on ‘Collective bargaining’). It is a complex exercise to establish cross-national definitions and categories of public and private LTC, which can refer to legal status, ownership and economic activity (with these three aspects not always aligned) (Eurofound, 2017a). Furthermore, a provider may legally be a private non-profit provider but be publicly funded. For instance, in Cyprus, in 2019, private non-profit LTC homes and day-care providers received €1,097,545 in public social welfare service subsidies. Workforce data add another layer of complication. For example, private care homes may have publicly employed managers, and a public provider may employ or contract out to private services, with privately employed staff working alongside publicly employed staff. In addition, being publicly employed has different meanings across Member States, and differs to varying degrees from private employment.

Specific data on the numbers of workers in public and private care homes were identified for six countries (Belgium, Croatia, Greece, Hungary, Malta, Slovenia) and in home care services for four countries (Austria, Romania, Slovakia, Slovenia). In other countries (Denmark, Lithuania, the UK) the data available concern social care in general. These data are presented in Table 4. Most information excludes LTC workers directly employed by households.

In several countries, no data were identified on the numbers of workers in public and private LTC, but this disaggregation is available for the number of LTC-providing entities. It seems intuitive to use the market share (in terms of the number of providers, care homes or places) as a proxy for the public–private share of workers, but this can be misleading. For instance, the number of places in care homes can differ greatly between private and public providers. Public care homes in several Member States are larger than private care homes (Eurofound, 2017a). In Romania, 22% of providers are part of, or subordinated to, public central or local administration. Others are privately run (78%), with 13% owned by for-profit providers and 65% by non-profit providers. However, public providers employ most employees in the sector (almost 89% of all social services employees), followed by private non-profit (around 9%) and for-profit (2%) providers. In contrast to the share of establishments, the share of places does incorporate the size of the establishment. However, it can also be a deceptive indicator of rates of employment as there may be differences in occupancy rates between types of providers (and thus the need for staff). For instance, in Cyprus, public residential LTC providers have a capacity of around 120 residents (more than private providers), but occupancy is around 25–30 residents.

Overall, in Romania, Slovakia and Slovenia, the majority of the LTC workforce is employed in the public sector. The split between public and private sector LTC employment is about equal in Croatia and Hungary. In Austria, Greece, Malta and the Netherlands the workforce is entirely or almost entirely concentrated in the private sector, which may be for-profit or non-profit.

Table 4: Estimates of the LTC workforce by setting, 2018

	Public-private split*	Source
AT	Home care: 100% (21,578 workers, 12,547 FTE) non-profit Care homes (ownership): 44% public, 31% non-profit, 25% for-profit	Statistics Austria (2018)
BE	Residential LTC (185,410 workers): 23% public, 77% private Non-residential care (171,674 workers): 15% public, 85% private	ONSS (2017)
BG (2017)	Social services: 89.2% public (10,771 residential LTC and 15,926 non-residential care) (90% of LTC services are public, provided by national or local government; non-profit organisations are increasingly involved in rehabilitation LTC day centres; home LTC is provided by individuals contracted by local or national government)	National Statistical Institute; NEC
CY	Residential LTC: mostly public, followed by private for-profit and some private non-profit Home LTC: all organisations are private non-profit; some self-employed contracts	NEC
CZ	Residential LTC: 34% public, 6% private non-profit, 59% private for-profit Home-based healthcare agencies: 10% public, 28% private non-profit, 60% private for-profit	UZIS ČR (2018)
DE	Residential care: mostly public sector workers Care homes (ownership): private: 6,167 for-profit and 7,631 non-profit; public: 682 Non-residential LTC: most workers are employed in non-profit organisations; public sector employment ranks second	Destatis (2018); NEC2
DK (2016)	Public: 89% of social and healthcare workers (79% employed by local authorities, 10% by regions) Private: 11%	FOA (2017)
EE	Human health and social work activities: most (63%) employees work in the public sector (for local and central government). Most social services are the responsibility of local governments but are provided by private companies. Health services are the responsibility of central government.	NEC2
EL (2016)	Residential LTC (4,322): 44% for-profit, 56% non-profit or state-owned Home care: 860 'help at home' schemes in operation, run by 282 agencies (municipalities, municipal enterprises, non-profit organisations, etc.; 68 KIFI (day-care centres for older people)); 12 regional 'social welfare centres' consisting of 44 social care units (2017 data) Day-care centres: all public	Data provided by the Ministry of Employment in 2017
ES (2019)	Care homes (ownership, 372,985 places): 27% public, 73% private places	Abellán García et al (2019)
FI	Residential care and home care: 65–70% public, 15–20% private non-profit, 20–25% private for-profit	NEC estimate based on the public sector producing 65% of the value of social services in 2015. Non-profit organisations produced 16% of the value and for-profit organisations produced 19% (Statistics Finland's annual national accounts).
FR (2015)	Residential LTC FTE: 53% public sector civil servants, 19% for-profit, 27% non-profit Home care ( <i>service d'aide à domicile</i> ): 20% for-profit, 70% private non-profit, 10% public	Ministry of Social Affairs and Health (2019a)
HR	Residential LTC (about 137,000, covering all professions including cooks, administrative staff, cleaners): 52.6% public, 36.5% private for-profit, 10.9% private non-profit	MDOMSP (2018); data adjusted according to expert opinion

	Public-private split*	Source
HU	Residential LTC (care homes): Non-profit operated: 18% church, 17% other non-profit Publicly operated: 37% by national government, 28% by local government	NEC
IE	Residential and non-residential care: mostly public employees (Health Service Executive) Private residential care: 35,000 direct employees	Nursing Homes Ireland (2019)
IT	Social services: 10% public, 46% private non-profit, 44% private for-profit	Lethbridge (2017)
LT	Social services: 77% public, 10–20% private for-profit, 5–10% private non-profit	NEC2
LU	All non-profit	NEC2
LV (2019)	Residential LTC (6,981 workers): 48% in state-owned or private (for-profit/non-profit) organisations contracted by the state, and 52% in local government-owned and other organisations Home care: local governments are in charge of home care, part of which is public and part of which is contracted out to private providers	NEC
MT (2019)	Residential LTC (7,256 workers): 26% public, 74% private	Jobsplus
NL	Residential LTC: all private non-profit Home care: all private for-profit or non-profit	NEC
PL	Health and social care: 79% public, 21% private	Statistics Poland (2018)
PT	Social services: about 95% private (about one-third for-profit, two-thirds non-profit), about 5% public	NEC2
RO	LTC (85,972 employees): 89% public, 2% private for-profit, 9% private non-profit	Calculations based on data from the National Institute of Statistics TEMPO online database
SE	Social services (486,900): 50% public (residential LTC: 82%, non-residential care: 17%), 50% private (residential LTC: 18%, non-residential care: 83%)	NEC
SI	Residential LTC (12,125 workers): 76% public, 24% private Home LTC: 87% public, 13% private	IRSSV (2019), SSVS (2019)
SK	Residential elderly care (by ownership of all 606 establishments): 56% private (for-profit and non-profit), 44% public (2020) Home care (8,525): 67% public, 33% private non-profit	Ministry of Labour, Social Affairs and Family of the Slovak Republic, reports on the social situation of the Slovakian population from the Institute of Social Policy
UK (England)	Adult social care (about 1,650,000 FTE): 78% private, 9% direct payment, 7% public local authorities, 6% NHS	Skills for Care (2019)

**Notes:** Estimates are complemented with qualitative expert opinion, largely based on input from the Network of Eurofound Correspondents. ‘NEC2’ refers to the 2020 Network of Eurofound Correspondents’ input to the study on the representativeness of trade unions and employer organisations in the social services sector, while ‘NEC’ refers to the input for this report. ‘Non-residential care’ (rather than LTC) refers to NACE 88 so includes childcare. \*The total number of workers is provided where identified; all data are in terms of employees unless mentioned otherwise. When no workforce estimates were identified, a breakdown by providers or a broad description is presented. Any differences in totals that arise are due to rounding.

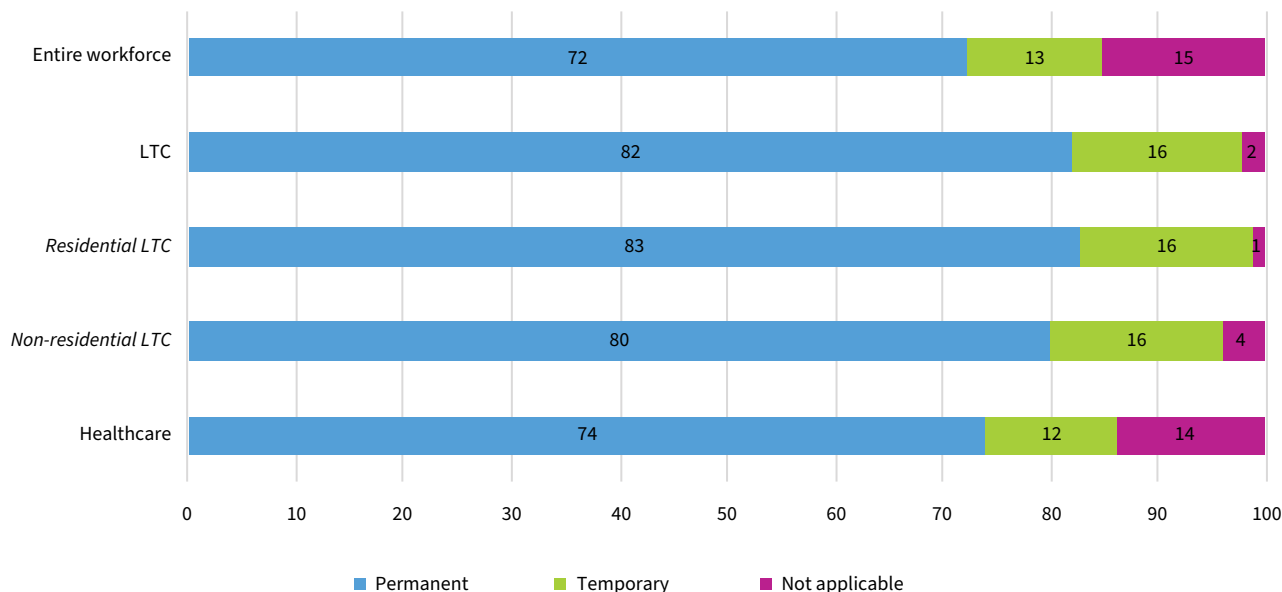
In countries where trend data were identified, an increase in employment in the private sector was noted (Malta, the UK). In Spain, public employment in LTC decreased in the aftermath of the 2007–2008 global financial crisis (Mercader Uguina et al, 2020). While it has recently increased, it has remained at around 20% of 2011 levels; growth has mainly come from the private sector. In Slovakia, the workforce split in 2013 was roughly 80% in the public sector and 20% in the private sector and since then has remained at around 60–67% in the public sector and 33–40% in the private non-profit sector. Other countries have also seen a decrease in the public sector

(for example, Cyprus). These observations are consistent with the privatisation and outsourcing trend documented elsewhere (ESPN, 2018a).

## Indefinite versus fixed-term contracts

Permanent contracts are more common in LTC (82%) than in healthcare (74%) and among all workers in the EU27 (72%). They are particularly common in residential LTC (83%), and less so in non-residential LTC (80%). Temporary contracts are

Figure 4: Types of contract: LTC, healthcare and the entire workforce, EU27, 2019 (%)



**Note:** Annual averages of quarterly data. ‘No answer’ responses are excluded from the data.

**Source:** Eurofound analysis of LFS extraction provided by Eurostat

also more common in LTC than in healthcare and overall, but the difference is smaller: 16% in LTC (both residential and non-residential), compared with 12% in healthcare and 13% in the economy as a whole. Figure 4 summarises the data on types of contracts in LTC, healthcare and overall. Most of the ‘not applicable’ responses relate to people who are self-employed (see section on ‘Self-employment’). Besides being more common in non-residential LTC (in Croatia and Spain, over 30% of LTC workers have a temporary contract: 33% and 31%, respectively), temporary employment may also be more common among certain groups of workers. For instance, in Sweden, temporary employment is more common among migrant LTC workers (Kommunal, 2016).

Some LTC workers are employed by temporary job agencies. Agency work mainly occurs in home care and in some countries is frequent in live-in care (see section on ‘Live-in care’). For instance, in Austria, labour market intermediaries (placement agencies) play a key role in recruiting foreign carers for private households (in late 2019 there were 826 companies operating in the labour market, with about 62,000 self-employed 24-hour care workers); intermediary agencies also play a role in the emerging live-in care market in the Netherlands, with companies specialising in recruiting foreign au pairs or workers from eastern Member States entering this niche area.

## Zero-hour contracts

In some Member States, zero-hour contracts are illegal (Austria, Lithuania, Poland, Spain). In Poland and Slovenia, there are no zero-hour contracts, but employers may demand overtime from part-time workers if written in their contracts (Slovenia), or self-employed workers may have few guaranteed hours (Poland). For instance, zero-hour contracts are more common in the following countries:

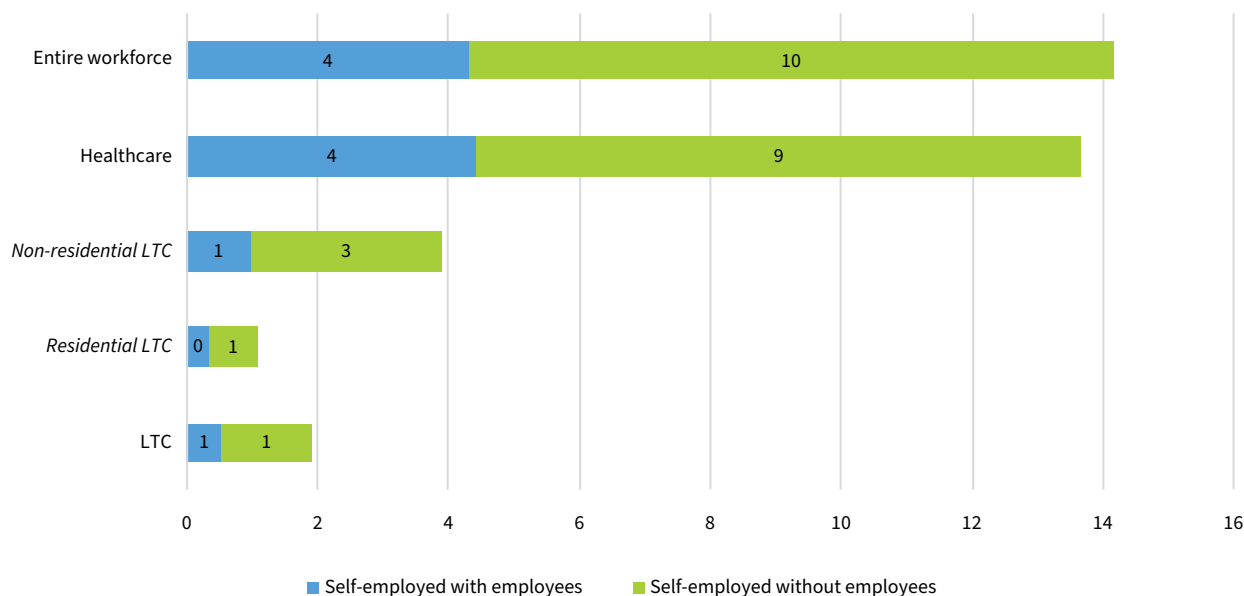
- Finland:** Zero-hour contracts are more common in health and social care (15,000 contracts) than in other sectors (Statistics Finland, 2019). Since a set of amendments limiting zero-hour contracts entered into force in 2018, the use of such contracts in the LTC sector has decreased, but pay-by-task for an on-demand service model (‘gig contracts’) seems to have become more popular (see the section on ‘Platforms’ for more information on on-demand services).
- Sweden:** In 2015, 25% of LTC workers in elderly care were on a fixed-term, zero-hour or ‘employed by hour’ contract. These types of contracts are more common in the private sector. The smaller a company is, the higher the likelihood that staff are employed on a temporary or hourly contract (Kommunal, 2016).
- UK:** In 2019, 24% of the adult social care workforce was employed on a zero-hour contract (370,000 jobs). Rates were particularly high for care workers in domiciliary care services (58%). The percentage of workers employed on a zero-hour contract decreased by 1 percentage point between 2012/2013 and 2018/2019 (Skills for Care, 2019).

## Self-employment

In the EU27, in 2019, only 1.9% of workers in LTC were self-employed, compared with 13.7% in healthcare and 14.2% in the entire workforce (Figure 5). This represents a slight increase since 2009, when 1.7% of LTC workers were self-employed. Self-employment is more common in non-residential LTC (3.9%) than in residential LTC (1.1%). EU-LFS 2019 data suggest it is relatively common in non-residential LTC in Italy, Lithuania, the Netherlands, Poland, Slovakia and the UK (all above 4.5%).



Figure 5: Self-employment in LTC, compared with healthcare and the entire workforce, EU27, 2019 (%)



**Note:** 'No answer' responses are excluded from the data.

**Source:** Eurofound analysis of LFS extraction provided by Eurostat

Input from the Network of Eurofound Correspondents confirms that self-employment is rare in LTC but is more frequent in specific countries and subsections of LTC:

- **Belgium:** Self-employment is most common among home care nurses and physiotherapists.
- **Croatia:** In residential LTC, self-employment is concentrated in private sector LTC.
- **Cyprus:** An estimated 80% of the 220 (fully or partially) registered home carers are self-employed, contracted by a community home care provider or by the care recipient.
- **France:** The self-employed include some nurses visiting older people at home.
- **Netherlands:** The self-employed are mostly freelance carers who offer services locally to those needing care around the home, along with informal carers. Furthermore, caregivers providing social services at local and regional levels can be self-employed.
- **Poland:** Several LTC organisations hire self-employed nurses.
- **Portugal:** Almost half (49%) of the 407 public and private residential LTC nurses of the National Network for Integrated Long-term Care in the centre regional section (112 residential LTC units) are self-employed (Oliveira Neves et al, 2019).
- **Slovakia:** The rate of self-employment is low in LTC compared with healthcare, although it is growing in LTC and dropping in healthcare. It is also low compared with self-employment in other (non-residential) social services. Self-employment in LTC is concentrated in non-residential LTC (371/7,425, 5.0% in 2019) and is rare in residential LTC (38/26,101, 0.1%). Nurses and other LTC workers are instead employed by staffing companies.

- **UK (England):** An estimated 145,000 personal assistants are employed by personal budget recipients and self-funders, usually on a self-employment basis (National Audit Office, 2018).

Certain policies have impacted on the prevalence of self-employed workers:

- Low-barrier self-employment options have been used to regularise domestic care work (Austria, Lithuania). In Lithuania, self-employed workers are allowed to provide home LTC only by obtaining a business certificate for this type of activity; 0.2% of LTC workers have a business certificate. In Austria, self-employment in LTC largely concerns live-in carers, as a 2008 regulation addressed undeclared work by requiring live-in carers to register as self-employed or employed. In countries where live-in care is largely undeclared, self-employment is rare in this group (Spain).
- Self-employment can be generally attractive for workers and/or employers from a fiscal point of view or in terms of employer–employee social security payments, flexibility or salaries. In Sweden, skilled nurses and doctors are often self-employed, allowing them to be paid higher salaries by municipalities facing difficulties finding staff (assistant nurses tend to be hired by for-profit staffing companies and paid a collectively agreed salary). In Greece, along with specific disincentives for self-employed carers, self-employment has generally been discouraged by increasing social insurance contributions for self-employed workers, equating the self-employed with salaried employees.
- Legal restrictions can also affect self-employment rates. For instance, in Austria, nursing assistants are not allowed to be self-employed by law. Restrictions on 'bogus self-employment', and their enforcement,



also impact on prevalence (see the end of this section).

Some of these national sources are in agreement with the EU-LFS data. For instance, in Cyprus, EU-LFS data indicate a 6% self-employment rate in LTC, mostly in non-residential LTC. In Croatia, the self-employment rate is 5% in LTC overall (similar in residential and non-residential care). The national sources presented add more precise indications about which groups include self-employed workers.

Usually, however, it is hard to identify these pockets of self-employed LTC workers in the LFS data. For instance, in Portugal, the rate of self-employment in residential and non-residential LTC does not differ significantly from zero according to EU-LFS findings. EU-LFS data indicate self-employment rates below 1.0% for both residential and non-residential LTC in Sweden. Similarly, for Austria, these data reveal self-employment rates of well below 1.0% in both residential and non-residential LTC. However, live-in carers may be underrepresented in the LFS sample. For Lithuania, the data confirm little self-employment in non-residential LTC (below 1.0%), with a rate of 2.5% for LTC overall (mostly in residential LTC).

Overall, self-employment seems to be least common in public residential LTC. Sometimes, specific professions conducting LTC work are self-employed (physiotherapists, doctors). It is particularly common in home care, which may be publicly financed, but the role of the public sector in its delivery is smaller. Self-employment is often concentrated in domestic LTC, where households with LTC needs hire a carer.

While not the focus of this research, informal caregivers (relatives or friends who provide care for the LTC user) may be registered as self-employed and be paid by the care receiver (through care subsidies or otherwise) or municipalities (for example, Latvia). For instance, in Luxembourg, paid family caregivers represent 94% of self-employed LTC workers.

Self-employed workers are sometimes excluded from statistics, for instance because households are excluded as employers, or because the workers are mainly employed in the healthcare sector and provide LTC as a side job. Studies on LTC also frequently exclude the self-employed (Bauer et al, 2018; Kuznecovienė and Naujanienė, 2015; Naujanienė et al, 2016). This is partly because of the limited statistics available, but also because they may focus on sections of LTC where provision or contracting is more in the public realm (self-employment may be covered by public vouchers/benefits, but be considered private), for which it may be easier to obtain data or which are considered to be of more direct policy relevance.

Self-employment, except for some higher paid professionals, is often not the most attractive type of employment in LTC. For instance, in Cyprus, self-employed home care providers earn €7–8 per hour and must pay 14% of their income in social security contributions and 2.65% in health insurance contributions, with no payment for annual leave. In Germany, a study showed that it is

uncommon for LTC workers to move from employment to becoming self-employed.

Some self-employment in LTC could be classified as ‘bogus self-employment’ or is unlawful. For instance, in Italy, the national labour inspectorate identified a relatively large number of misclassifications of self-employment in the ‘human health and social work activities’ sector (type of LTC not specified): 18% (1,035) of a total of 5,827 inspections, compared with less than 2% in all sectors (Ispettorato Nazionale del Lavoro, 2020). In Lithuania, to reduce taxes, some companies do not enter into employment contracts, but require workers to have business certificates in order to provide services, even though those with business certificates are not allowed to work in a self-employed capacity for companies engaged in identical activities. In 2014, the inspectorate found five such cases in private nursing homes. In Germany, some live-in carers are self-employed: either agencies broker contracts with them or they are freelancers registered as self-employed in Poland. Both forms are in the ‘grey zone’ or are unlawful (Jaehrling and Weinkopf, 2020).

## Platforms

In platform work in LTC, an online platform is used to enable organisations or individuals to access other organisations or individuals to provide LTC in exchange for payment, based on the performance of individual tasks or projects rather than a continuous employment relationship.

Platforms emerged in some Member States as an extension of their activities in the US and elsewhere, mainly in home care. The nearly simultaneous emergence of these platforms in most Member States suggests an upward trend (EESC, 2020a). Examples include Pflęgix and Pflęgetiger (Germany), Curafides (Austria), Home Care Direct (Ireland, UK), Care.com (10 Member States) and Nannuka.com (Cyprus, Greece, Ireland, the UK). Besides home care, they may also offer care services other than LTC, including babysitting and pet care (for example, Mindme.ie, Care.com).

Home care can be well suited to platforms, as mechanisms can be applied that minimise distances and travel time between workers and clients (travel may be unpaid) and increase choice of carers for users. However, platforms for domestic services tend to be focused more often on services such as cleaning than on care work (for example, Finland). LTC workers usually need at least a certain level of qualification, even if regulation or governance specifying this is sometimes lacking (Schulmann and Leichsenring, 2014). Even if carers are personal care workers rather than nurses, experience and eligibility criteria may exclude some candidates. This contrasts with other occupations for which platforms are most common, such as passenger transport, cleaning or food delivery, characterised by low entry barriers and high competition among workers (Eurofound, 2018; EESC, 2020a). Another difference is that the public sector tends to have a larger role in LTC provision or funding.

## Undeclared work

### Prevalence

In many Member States, undeclared work is less common in LTC than in other sectors of the economy, often because LTC is regulated, managed and provided by the public sector (mostly by local authorities) or through registered social service providers (Bulgaria, Estonia, Latvia). However, even in countries where it is uncommon, some undeclared work in LTC is carried out outside these frameworks, especially in domestic care. However, in lower-income Member States, few people can afford this type of LTC service.

Overall, undeclared LTC work seems to be most common in countries where wages are above the EU average, LTC entitlements are limited or consist of cash payments with little control over their usage, and there is a large role for domestic LTC, usually carried out by migrants (Croatia, Germany, Greece, Italy and Spain). Such undeclared work usually relates to the entire job for a household (even if the worker may still provide declared LTC elsewhere).

In countries where home care is more formalised and undeclared work seems to be relatively rare, domestic workers may occasionally provide a few hours of undeclared care (or housework) in addition to their declared work for a specific care receiver. For example, in Denmark, more hours than are assigned by the municipality may be provided, in particular for support with IADLs, including cleaning, where entitlements have decreased. In France, providers may not declare some additional hours (Ministry of Social Affairs and Health, 2019b).

In some countries, documents acknowledge the presence of undeclared work and experts point to undeclared work being widespread, but estimates are lacking. Even though estimates of undeclared work may be gathered regularly for other sectors, they may be unavailable for LTC specifically (Latvia, Romania). The following country estimates of the numbers of undeclared workers were obtained:

- **Croatia:** The prevalence of undeclared work in Croatia is stable, at around 10% of GDP, but is higher in service sectors characterised by a high contribution of human work, at around 20% of GDP (Lovrinčević et al, 2011). It is expected to be higher in LTC, mainly in home care, with around two-thirds of these jobs being undeclared; this work is often carried out by retired women with small pensions.
- **Cyprus:** There are an estimated 10,000 undocumented and undeclared migrant domestic workers in Cyprus (ESPN, 2018b).
- **Germany:** An estimated 180,000–200,000 households employ an undeclared live-in carer; as they usually work in rotation, this corresponds to a total of around 300,000–350,000 undeclared live-in carers (Horn and Schweppe, 2019b).
- **Italy:** There are an estimated 600,000 domestic workers in Italy (Fosti and Notarnicola, 2019).

- **Malta:** 2% of the Filipino working community in Malta (not limited to, but probably mostly, those carrying out care work, often live-in care) do not have a work contract (Debono and Vassallo, 2019).
- **Poland:** In 2017, 5% of private households offered undeclared work, of which 9% was in child or elderly care (GUS, 2019). In the Opolskie region, 60% of migrants – mostly Ukrainian – were carrying out elderly home care work illegally (Rynek Zdrowia, 2019).
- **Slovakia:** In 2014, 49% of 247 state administration and 37 self-government expert officials reported that undeclared work in elderly care occurs occasionally, and 7% reported that it occurs to a significant extent (Bednárík, 2014).
- **Slovenia:** In 2009, 5% of households were reported to employ domestic workers (17% of foreign origin, mainly the former Yugoslavia), of which 23% were employed to carry out elderly care, 81% were employed for cleaning, 10% were employed for babysitting and some were employed for more than one task. This work is mostly undeclared.
- **Spain:** An estimated 32% of employment in personal household services was undeclared in 2019 (about 185,000 workers). This proportion has been rather stable following a large drop from 2011 to 2012, likely due to job losses in the aftermath of the global financial crisis disproportionately affecting undeclared domestic workers (Mercader Uguina et al, 2020).

Information on undeclared work also comes from data provided by control bodies, mainly labour inspectorates. Such data mainly concern residential LTC and home care provided by organisations, as inspectorates do not inspect the most common employer in undeclared LTC work: private households (see section on ‘Policies to combat undeclared work’). Breakdowns often do not allow LTC to be distinguished from healthcare. They can reveal some information about the formats of undeclared work in these organisations and about the prevalence of undeclared work in comparison with other sectors, but should be interpreted with caution as they depend on how well targeted inspections are and how active inspectorates are. The following country data were identified:

- **Italy:** In 2019, of the 32,367 inspections carried out in the ‘human health and social work activities’ sector, 568 instances of undeclared work were identified, a rate of 1.7%, similar to that found in other sectors (Ispettorato Nazionale del Lavoro, 2020).
- **Lithuania:** From 2015 to 2019, 37 inspections of residential LTC entities identified three undeclared workers and 16 people carrying out undeclared work.
- **Slovakia:** Between 2015 and 2018, identified violations (undeclared work or other) in health and social care varied between 1.4% and 3.1% of all cases.

To illustrate the processes and issues behind these numbers, in Lithuania in 2014, a call was made on a confidential telephone line alleging that a private nursing services provider was making undeclared wage payments.

An inspection revealed that income received from 22 of its 43 care receivers was undeclared, resulting in over €58,000 annually of hidden income relating to undeclared wages and (in the case of two workers) an absence of contracts.

### Reasons for level of undeclared work

Undeclared work is particularly common in households hiring individual home carers. Declared care can be more costly for employing households and comes with lower income for carers (for example, Germany – Horn and Schweppe, 2019a). Often, work goes undeclared by employers and workers to avoid paying taxes and social contributions. If care is provided by people in receipt of a public pension or other benefits, not declaring income may prevent pensions and benefits from being reduced (Eurofound, 2012). The inflexibility of home care providers in the format of care provided (for example, unavailability at the weekends or after business hours) contributes to LTC being met by undeclared workers (Kuznecovienė and Naujanienė, 2015). Until a person's health deteriorates too much, home care (sometimes live-in care) is often the preferred option, or the person in need may not yet be entitled to nursing home care (which tends to be declared). In addition, it may be more straightforward to hire someone on the black market than undertaking, as an individual household, the complex processes required to register such work. Lack of professionalisation of care in countries with a tradition of intrafamilial care seems to be translated into similar arrangements, even when care is provided by an external actor, opening up undeclared work for people without formal LTC skills (for example, Greece, Italy, Spain).

### Live-in care

Live-in carers are paid professionals, with or without formal care training, whose work primarily involves LTC provision while living in a private residence with the care receiver. This role comes with specific challenges and in some cases has been classified as 'modern slavery' (EESC, 2016, 2020b). While live-in care is a type of LTC provision rather than a form of employment, it is singled out in this chapter, as precarious employment arrangements are particularly common in live-in care and it is not always captured well by data on forms of unemployment. Little solid information is available on live-in carers, partly because live-in care is often unregulated and undeclared, sometimes involving undocumented migrants, and partly because employers are often single households, making data collection a challenge and sometimes less of a priority. Furthermore, there is no occupational definition of a live-in carer. Live-in carers come under different categorisations at EU and Member State levels and may be recorded as domestic workers or care workers (EESC, 2016).

### Prevalence and characteristics

Live-in care is relatively common in seven Member States: Austria, Cyprus, Germany, Greece, Italy, Malta and Spain. It also occurs in the UK. In other Member States and Norway, live-in care is a marginal phenomenon, mainly restricted to a small group of wealthy users (in lower-income Member

States) or to very specific cases of LTC needs (in higher-income Member States with relatively comprehensive LTC systems), such as occasional end-of-life care (Denmark). However, in some Member States where live-in care is uncommon, there have been signs of recent increases (the Netherlands, Poland, Slovenia).

Live-in care differs between Member States in terms of the country of origin of the carers, formalisation and care arrangements. Earnings are particularly low (see section on 'Earnings'), although live-in carers generally do not pay for their accommodation and food, and sometimes receive paid trips to their home country (for example, live-in carers in Malta typically receive a paid trip home once a year). Sometimes their work is undeclared (see section on 'Undeclared work') or irregular in other ways. For instance, in Cyprus, live-in carers are sometimes registered as housekeepers rather than carers and are therefore not covered by the Minimum Wage Law, which specifically applies to certain professions (including carers, not housekeepers). Live-in carers often work long weeks. In Greece, for example, the many undeclared live-in carers usually only have a half-day or one full day off a week on Sundays.

In Cyprus, most live-in carers are from the Philippines and Sri Lanka. In Malta, most are from the Philippines. In Spain, most live-in carers are from Latin America (mainly from Ecuador) and many are (or started working as) undocumented migrants. In Austria and Germany, most are from eastern Member States, mainly neighbouring ones (Slovakia and Poland, respectively). There is also regional variation in the country of origin of live-in carers. For instance, in Italy most live-in carers are from the Philippines (and less so from Romania), but in areas that border Croatia, many are Croatian. In 2016, half of the Slovakian carers in Austria came from the eastern part of Slovakia, while the other half were from the central and western part of Slovakia. However, live-in carers may also come from other countries. For instance, hundreds of Bulgarian women work as live-in LTC workers in Austria, Belgium, Germany, the Netherlands and the UK. Other common destinations for Bulgarian care workers are Greece and Spain.

In countries where live-in carers are rarer, their country of origin also differs between countries. In Slovenia, there are some Croatian live-in carers (Hrženjak, 2018). In Hungary, there are some live-in carers from the poorer, eastern regions of Hungary, as well as ethnic Hungarian live-in carers from neighbouring countries, mainly Romania and western Ukraine. In Poland, the few live-in carers are mainly from Ukraine and Belarus, working for a small group of wealthy households. In both Poland and Slovenia this is mainly restricted to urban areas. In Croatia, there are some live-in carers from Bosnia and Herzegovina, and in Portugal from Brazil and Portuguese-speaking African countries.

Sparse data give an idea of the numbers involved. In Austria, 21,900 people used their LTC allowance for live-in care in 2015 (up from 3,200 in 2008) (WIFO, 2017). Most people employ two carers, with 60,000 live-in carers registered in 2016. Most carers came from Slovakia (47%)

or Romania (37%). Other data – which include the (few) undeclared live-in carers – suggest that there were 26,500 Slovaks working as live-in carers in Austria in 2015, which has since declined to around 23,000 (Bahna and Sekulová, 2019). Similarly, Croats make up only 2% of registered live-in carers, but the real number of live-in carers may be higher (Pandžić, 2018). In Malta, there are 209 home-based care workers, of whom 174 are from the Philippines and are probably mostly live-in carers. In England, there were an estimated 145,000 ‘personal assistant carers’ in 2016–2017, but it is unclear what proportion were live-in carers (National Audit Office, 2018). In Italy, in 2018, about 40% of the 402,413 regular domestic care workers, around 160,000 (up from around 300,000 in 2009), were probably live-in carers (DOMINA, 2019; Fosti and Notarnicola, 2019). If undeclared work is counted, the number may be double. In Spain, there were an estimated 113,200 domestic care workers (69,000 migrants) with or without a contract in 2017 (including childcare). This represents an increase of 8% since 2008, while the overall number of domestic workers has decreased (Díaz Gorfinkiel and Martínez-Buján, 2018). In Cyprus, between May 2018 and May 2019, 20,543 migrants received a residence permit to work in domestic employment (InCyprus, 2019). Furthermore, it has been estimated that 10,000 migrants are undocumented (ESPN, 2018b). Many of them are involved in care work. An estimated 300,000 live-in care workers are employed in Germany (EESC, 2020b). Of the Polish workers employed in other countries, those in Germany are most likely to work in household assistance or care services (9% in 2016; 1%, 3% and 4% in the Netherlands, Ireland and the UK, respectively), although not necessarily as live-in carers (Chmielewska et al, 2018). In the Netherlands, a few hundred live-in carers were registered in 2014 (mainly from Czechia and Poland, but increasingly from Greece and Portugal).

In Austria and Germany (and Slovenia on a much smaller scale), in particular, live-in carers tend to work particular shift patterns, especially carers who come from nearby areas in bordering Member States (for example, Slovakian workers in Austria). In Austria, carers usually work for 2-week periods (as regulated by law), while in Germany working periods are usually longer and flexibly agreed on. Users usually have two alternating carers (occasionally a mother and daughter). More often than in other countries, these carers are skilled or retrained nurses; however, most do not have any related formal training. For instance, among Slovakian live-in carers (mainly working in Austria) in 2016, 20% used to work as nurses in healthcare in Slovakia (Bahna and Sekulová, 2019). In Poland, some migrants provide live-in care for a maximum of three months and then return home for a few months.

In countries where live-in carers tend to come from further away, they usually live more permanently in the care user’s home (for example, Portugal (Perista et al, 2017)). In Malta, Filipino live-in carers usually work six days per week, 24 hours per day, with one day off a week, and have one month’s leave per year (Galea, 2018).

In Norway, live-in care is mainly restricted to carers living in with the care receiver in a residential home rather than in a private home. Until 2006, employees could work for

25 days followed by 17 days off; however, in 2006 it was decided that a working period of 25 days was too long. One alternative used currently is to work for 14 days followed by 14 days off. Some residential LTC providers use a rotation whereby employees are three days at work, off for seven days and are then at work for four days before they have seven days off again. In some residential care homes, the working time rotation (for example, 14 days on, 14 days off) is established through a collective agreement instead of through government regulation.

If a formal arrangement exists, live-in carers are usually not self-employed or directly employed by households, but rather employed through an intermediary agency (EESC, 2020b). The role of these agencies differs across countries. For instance, in the Netherlands, most registered live-in carers are employed through Dutch agencies. Polish care workers posted to Germany by Polish agencies are often not directly employed by German care service-providing agencies (EESC, 2020b). In Bulgaria, agencies from various Member States offer different shift patterns for Bulgarian live-in carers who like to work abroad but who also like to return home on a regular basis. There are also examples of initiatives between private individuals and NGOs/other agencies that help to match people looking for caregiver work with those who are looking to employ a carer, such as nontusolus.hu in Hungary. In Luxembourg, even though infrequent, live-in care can be purchased within the elaborate LTC insurance system, for instance through the company Mateneen.

### Reasons for choosing live-in care

The reasons for opting for live-in care include users’ preference to stay in the home environment (because of an unwillingness to ‘put people away’ in a care home (EESC, 2016) and deinstitutionalisation processes), in combination with access barriers to alternative home care options, such as cost, low quality (seeing many different faces, limited personal attention), and unreliability or unavailability at times when needed. Barriers to accessing good-quality residential LTC also play a role, such as high costs or waiting lists (Eurofound, 2020). Live-in care may be facilitated by allowing it to be paid for from care subsidies (for example, in the Netherlands (Da Roit and van Bochove, 2015) and Malta, where a ‘carer at home’ subsidy of €5,200 per year was introduced in 2017), including cash-for-care schemes, where receivers do not have to declare what the money has been spent on (for example, Germany). An increase in the ability of people to afford live-in care also plays a role (Poland, Slovenia).

There are also constraints on (the growth of) live-in care, such as uncertainties around regulations (for example, whether or not care subsidies can be used for a foreign healthcare provider under contract in the country of origin, see Da Roit and van Bochove, 2015), legislation that judges live-in care arrangements illegal (Norway) and limitations on the allowed duration of employment of migrant live-in carers (the Netherlands). Limited incentives for investment by intermediaries in matching carers and users as care is often for a short duration (Da Roit and van Bochove, 2015), an inability to afford live-in care because of the high cost (Finland) and the low salaries of those with



LTC needs are other constraints. For instance, in Malta, pensions are usually less than €700 per month, below the cost of a live-in carer even when subsidised (see section on ‘Earnings’). Housing space is also an important limitation, with live-in carers sometimes having to sleep in the same room as the care receiver (for example, Poland).

Migrant live-in carers may see their work as a starting point for taking root in a country with more opportunities (see section on ‘Migrants and mobile citizens’). In Poland, working as a live-in carer is more common for migrants who have just arrived in the country than for those who

are already in the country. It allows them to minimise living costs while making new contacts and gaining a better understanding of the labour market (Kindler et al, 2016). For other migrants it can be a long-term life strategy. The alternative may be a lower salary or unemployment in their country of origin. For instance, Croatian live-in carers working in Austria or Italy can earn in two weeks what they would earn in three to four months for similar work in Croatia. Over half of Slovak live-in carers in Austria who started care work after 2013 report unemployment as the main reason for leaving Slovakia (Bahna and Sekulová, 2019).

# 3 Working conditions

Overall, 81% of LTC workers report being satisfied (satisfied or very satisfied) with their working conditions, compared with 86% of all workers in the EU and 86% of workers in healthcare (EWCS 2015). In total, 22% of workers in LTC are very satisfied (29% in healthcare, 26% of all workers). This chapter looks at the working conditions of the LTC workforce in more detail. First, general subjective measures of job quality are discussed. Then, the chapter focuses on specific working conditions for which LTC stands out from other sectors: earnings, working time, work intensity, physical risks, social environment, training needs (all negatively) and perceived meaningfulness of the work (positively).

## Job quality

Eurofound has developed indices (each consisting of various indicators) to investigate seven aspects of job quality overall (see Eurofound, 2019b, for details). Figure 6 provides an overview of how these job quality scores for LTC compare with those for the healthcare sector, other service sectors and non-service sectors. The LTC sector scores above average (blue bars) for job prospects and skills and discretion. It also scores higher than average for work intensity, but this means worse, rather than better, than average. LTC scores below average (orange bars) for physical environment, working time quality, social environment and monthly earnings. Scores for social environment and earnings compare particularly negatively with those for the healthcare and other sectors.

## Earnings

LTC workers feel less often (43%) than all workers overall (51%) and healthcare workers (47%) that they are paid

appropriately, given their efforts and achievements in their job (EWCS 2015). This section investigates pay levels and differences in LTC, makes comparisons with healthcare and discusses challenges in interpreting and comparing the data. It pays particular attention to low-paid jobs in LTC. It is important to keep in mind that many LTC workers work part time (see section on ‘Working time’) and so their income generally lies well below the monthly and annual wage data based on FTEs presented in this section.

## Average earnings across Member States

Table 5 presents median hourly earnings in residential LTC, non-residential care, all social services and healthcare as a proportion of national average earnings. As three-digit NACE codes are unavailable in the SES, the whole social services sector is considered (NACE codes 87 and 88). While NACE code 87 corresponds to residential LTC, NACE code 88 includes non-residential LTC (NACE code 88.1) but also other non-residential social services, such as child day care. In this section, NACE code 88 will be referred to as non-residential *care* rather than non-residential *long-term care*.

In all Member States, average hourly earnings for social services (with a Member State average of €9.62) were below those for the economy as a whole (€11.98) in 2014. For 24 of the 27 Member States, average hourly earnings for social services are 10% or more below the national average earnings. The exceptions are the Netherlands, Austria and Luxembourg, where earnings in social services are 94%, 92% and 91% of average earnings, respectively. For over half of the Member States (14), earnings in social services are below 80% of average earnings.

These results contrast with healthcare, where earnings were below average only in France (95%), Greece (96%),

Figure 6: Job quality indices by sector, EU27 and the UK, 2015



Note: The plot shows scores relative to the mean in the overall workforce (z-scores).

Source: Eurofound analysis of EWCS data

Hungary (91%) and Poland (88%), with average earnings in healthcare (€13.27) well above those of all workers (€11.98). Social services compare particularly unfavourably to healthcare in Bulgaria, Estonia, Italy, Romania and Spain, where average earnings are more than 75% higher in healthcare. The difference between healthcare and social services is smallest in Austria, Denmark, France and Poland, where healthcare workers earn on average less than 25% more.

In 2010, earnings were higher in residential LTC than in non-residential care in 18 of the 27 Member States. This decreased to 16 Member States in 2014. Compared to

average earnings, earnings in non-residential care seem to have increased slightly from 2010 to 2014, while earnings in the (larger) residential care sector have dropped.

Overall, earnings in LTC have deteriorated slightly. In the aftermath of the 2007–2008 global financial crisis, LTC workers faced salary cuts. For instance, in Greece, the cuts suffered by public workers (including LTC and healthcare workers) amounted to 25%. Portugal froze wages in 2010; these were unfrozen in 2020 (career advancement was unfrozen in 2018). A similar observation can be made for healthcare, where earnings were also left behind those in other sectors.

**Table 5: Hourly earnings in social services (residential LTC and non-residential care) and healthcare as a proportion of national earnings, 2010, 2014, EU Member States and Norway and the UK (%)<sup>5</sup>**

	2014				2010			
	Healthcare (NACE 86)	Social services (NACE 87 and 88)	Residential LTC (NACE 87)	Non-residential care (NACE 88)	Healthcare (NACE 86)	Social services (NACE 87 and 88)	Residential LTC (NACE 87)	Non-residential care (NACE 88)
AT	104	92	93	91	108	86	86	86
BE	106	83	93	75	105	83	92	74
BG	121	67	67	67	121	66	68	63
CY	113	74	52	104	110	82	61	99
CZ	104	75	76	73	108	80	82	75
DE	107	81	82	81	106	80	81	80
DK	103	84	86	83	103	85	86	84
EE	108	62	60	66	112	64	62	68
EL	96	71	72	71	101	75	82	62
ES	128	72	70	75	135	74	72	76
FI	104	78	82	75	102	78	83	75
FR	95	77	82	73	99	79	87	73
HR	113	83	80	93	117	112	112	114
HU	91	68	70	66	87	68	69	65
IE	107	82	79	85	106	73	74	72
IT	120	66	68	64	130	63	64	63
LT	112	69	64	82	105	70	69	74
LU	145	91	101	83	146	96	108	87
LV	119	70	66	75	104	69	64	78
MT	119	81	79	92	107	82	79	95
NL	117	94	95	92	115	94	92	95
PL	88	86	89	82	98	86	90	79
PT	107	67	63	73	123	65	66	65
RO	118	60	61	58	104	52	55	45

<sup>5</sup> As detailed SES 2018 data were not available at the time of writing, a news update will be published on Eurofound's website in early 2021.



	2014				2010			
	Healthcare (NACE 86)	Social services (NACE 87 and 88)	Residential LTC (NACE 87)	Non-residential care (NACE 88)	Healthcare (NACE 86)	Social services (NACE 87 and 88)	Residential LTC (NACE 87)	Non-residential care (NACE 88)
SE	107	85	85	84	106	85	86	85
SI	117	80	78	87	120	84	82	91
SK	106	80	78	89	103	76	77	73
EU27 (Member State average)	111	80	81	81	112	81	82	80
NO	105	90	98	84	104	89	97	83
UK	110	69	65	73	115	70	64	75

**Notes:** All employees (including apprentices). All amounts are presented as a proportion of the average wage in NACE Rev. 2 sectors, sections B–S (except public administration and defence; compulsory social security).

**Source:** Eurofound analysis of LFS extraction provided by Eurostat

In addition to non-residential LTC not being distinguishable, for instance, from childcare in the data, there are other challenges in interpreting average differences between sectors and countries, and changes over time. For instance, such differences and changes may be due to the different and changing age profiles of staff. SES data include only LTC workers employed by organisations/companies with at least 10 employees. For the countries where 2018 SES data include smaller employers, average wages are lower for these smaller employers. They exclude, for instance, the many individual households that employ domestic carers. Furthermore, for many countries, the SES data do not include public administration jobs, so the overall average wage data do not include all workers in the economy.

### Low-end pay

Table 6 lists annual pay at the lower end of the scale for LTC professions in the Member States and the UK, and compares it with national average pay. Comparing annual figures generally is more accurate as in some countries annual holiday payments are standard, or annual payments include 14 (Austria, Greece, Portugal, Spain) or 13 (Belgium, Luxembourg, the Netherlands) monthly salaries per year.<sup>6</sup>

Such low-end paid jobs are common in LTC. For instance, in Sweden, the LTC workforce largely consists of ‘assistant nurses in the home and institutional care’. Table 6 aims to provide only an indication of pay and should be interpreted with caution. It focuses on the minimum pay set by collective agreements. When collective agreements were not identified, average wages are listed, which are higher. In addition, minimum collectively agreed salaries may cover only small sections of the workforce (see chapter on ‘Collective bargaining’). Finally, professions are not always comparable cross-nationally.

<sup>6</sup> Amounts in this chapter are for 2019, gross of taxes and on a full-time basis, unless specified. Except for hourly wages, amounts are rounded.

Table 6: Low-end pay in LTC, EU Member States and the UK

	Average wage*	Low-end pay in LTC (annual, 2019***)	Proportion of average wage (%)
AT	€46,506	Personal care worker: min. €29,064	62
BE	€46,140	Care personnel (nurses, carers, paramedic personnel): min. €27,044	59
BG	BGN 15,935 <sup>7</sup> (€8,147)	Social worker: BGN 7,800 (€3,988)	49
		Personal assistant: BGN 8,780 (€4,489) (2020)	55
CY	€25,847	Residential carer:	
		- public: min. €14,981	58
		- private non-profit: min. €11,310	44
		- private for-profit: min. €10,440	40
		Home carer (self-employed): min. €13,440	52
CZ	CZK 428,457 (€16,218)	Auxiliary nurse in residential care: average CZK 255,996 (€9,690) (2018)	60
DE	€44,933	Care worker with formal qualification: min. €35,202	78
DK	DKK 439,523 (€59,032)	Social and healthcare worker, no professional training: min. DKK 238,357 (€32,013)	54
		Social and healthcare worker: min. DKK 284,213 (€38,172)	65
EE	€17,013	Public sector:	
		- care worker: min. €10,080 (2020)	59
		- nurse: min. €16,120	95
EL	€22,142**	Private sector residential LTC: employees who are members of the Federation of Unions of Hospital Institutions of Greece (OSNIE) and work in residential LTC, which is part of the Greek Care Homes Association (PEMFI) (2017):	
		- assistant nursing personnel, social carer: min. €8,484	38
		- nursing personnel: min. €9,545	43
ES	€28,725	National agreement of care centres and services for people with disabilities (covering 200,000 workers): min. €13,860	48
FI	€48,193	Municipal practical nurse: min. €25,656	53
FR	€38,011	Private non-profit residential LTC (main collective agreement):	
		- care worker: min. €18,731	49
		- nurse: min. €25,455	67
HR	HRK 99,685** (€13,182)	Carer: min. HRK 53,160 (€7,030)	53
		Nurse: min. HRK 70,716 (€9,351)	71
HU	HUF 4,269,072 (€12,011)	Residential LTC nurse: min. HUF 2,004,000 (€5,638) (2020)	47
IE	€46,793	Healthcare support assistant (home help): min. €27,258	58
IT	€34,506**	Domestic services (2020), assisting a:	
		- non-self-sufficient person (not trained): €18,468	54
		- non-self-sufficient person (trained): €21,308	62
		- self-sufficient person: €16,576	48
		Residential LTC:	
		- social and healthcare assistant working in the socio-health structure: €20,091	58
		- generic nurse: €20,713	60

<sup>7</sup> All currency conversions in this report were carried out on 11 November 2020.

	Average wage*	Low-end pay in LTC (annual, 2019****)	Proportion of average wage (%)
LT	€11,959	Qualified social worker: min. €9,924	83
LU	€64,932	Caregiver: €41,673	64
		Graduate and specialist nurse: €60,967	94
LV	€14,733	Middle-level social carer: €7,296	50
MT	€26,419	Nursing aide and healthcare worker: €16,609	63
NL	€44,595	Lowest wage scale for adult workers in CAO VVT****, help with home care support, people aged > 20 years: €24,988 (2020)	56
PL	PLN 58,545 (€13,057)	Carer for older people: min. PLN 24,738 (€5,517)	42
		Nurse: min. PLN 24,738 (€5,517) (secondary education)	42
		But national minimum wage applies: PLN 33,852 (€7,550)	58
PT	€18,111	Support helper in facility for people with a disability: min. €8,568	47
		Direct action assistant (residential LTC): min. €8,708	48
		Nurse: min. €13,580	75
RO	RON 55,262 (€11,355)	Social assistant working in a social assistance facility or centre: min. RON 47,400 (€9,740)	86
		Nurse: min. RON 43,320 (€8,901)	78
SE	SEK 448,719 (€44,049)	Personal carer (age 19 years): min. SEK 248,820 (€24,426)	55
		Assistant nurse: SEK 282,750 (€27,757)	63
SI	€24,669	Social care worker: min. €10,500	43
		Nurse (secondary medical school): min. €13,286	54
		Nurse (diploma): min. €18,539	75
SK	€15,038	Carers and home care assistants for older people with disabilities: €7,644	51
		Carers and assistants in facilities for older people with disabilities: €9,192	61
		Nurse: €11,712	78
UK	GBP 35,659 (€40,007)	Registered nurse roles (average): GBP 30,400 (€34,107)	85
		Social worker (average): GBP 35,600 (€39,941)	100

**Notes:** \*2018 data from Eurostat, average annual earnings by sex, age and occupation – NACE Rev. 2 sectors, sections B–S, excluding O [earn\_ses18\_28], employers with 10 employees or more (wages for other years are given as a proportion of this 2018 average salary); \*\*2018 data were not yet available at the time of writing and adjusted 2014 data were used. \*\*\*Unless otherwise indicated, min. = minimum. \*\*\*\*Collective labour agreement in care and nursing homes and home care.

**Source:** Compiled and calculated by Eurofound from input provided by the Network of Eurofound Correspondents and Eurostat

Minimum pay in sectoral or company-level collective agreements and government regulations is usually specified for different professions (except, for instance, in Lithuania and Spain, where a general minimum salary is specified regardless of individual profession). Sometimes correction for inflation is included, but often the basic salary remains constant for the period covered by the agreement (for example, the amounts specified for Romania in Table 6 will apply until the government regulation expires in 2022).

In some countries, minimum rates for LTC workers in collective agreements do not increase with tenure with the same employer or sector (Denmark, Italy, Lithuania),

but usually they do, as in other sectors (Eurofound, 2019c). However, generally, even after several years of experience, they remain well below the average national salary. For instance, after 10 years of experience, the rates listed in Table 6 for Finland increase by 8% (to €27,696 – 57% of the national average pay), for Spain by 11% (to €15,357 – 53% of average), for Belgium by 20% (to €32,377 – 70% of average), for Ireland by 21% (to €33,038 – 71% of average), for Germany by 24% (to €43,543 – 97% of average) and for Luxembourg for caregivers by 31% (to €54,535 – 84% of average) and for nurses by 26% (to €76,916 – 118% of average). In Portugal, the minimum salaries for the three occupations listed in Table 6 increase by 3% (€8,848 – 49%

of average), 4% (€9,044 – 50%) and 10% (€14,994 – 83%), respectively, after 10 years of experience. The agreement presented in Table 6 for Greece specifies 5% increments on the basic wage for every three years of experience for up to four three-yearly periods (full time). In Bulgaria, a social worker's starting salary is BGN 7,800 (€3,983), increasing by up to 22% (to BGN 9,540 (€4,872) – 60% of average), usually reached after five years of experience. The salary listed for the Netherlands reaches a cap of €30,421 (68% of average) after six years. In Hungary, the salary of a residential LTC nurse with a college degree can reach HUF 3,731,000 (€10,501) (87% of average) after 27 years of experience (2020). LTC workers who are not covered by collective agreements and rely on minimum wages are usually not entitled to such increments.

Pay may be further increased above the minimum because of wage supplements. The sector has high rates of shift, weekend and night work (see section on 'Working time') and may attract wage supplements that are not included in the basic pay listed in Table 6 (Belgium, Denmark, Germany). In Finland, practical nurses in the public sector earn on average €34,440 per year, well above the amount in Table 6. Pay is higher for more demanding tasks, which are assessed by municipalities. In Czechia, workers in social services earn on average CZK 25,767 (€975) per month (2018), of which 22.2% is flexible (13.6% supplements, 0.2% overtime supplement and 8.4% performance reward). Some collective agreements specify the wage supplements that should be paid for atypical working times. For instance, the agreement for the social welfare sector in Croatia supplements the base wage at 40% for night work, 50% for overtime, 25% for work on Saturday, 35% for work on Sunday and 10% for two-shift work with a break of at least 90 minutes. There may be ceilings on supplements, such as in Lithuania, where the agreement states that supplements may not exceed 80% of the fixed part of the salary. Sometimes, pay is stipulated to be higher if a worker has children, such as in Greece, where a 5% allowance on the basic salary is paid for every minor (or studying) child of a public sector worker. As well as these wage supplements, 'overpayments' may be made on the collectively agreed minimum rates (this is less likely for the statutory rates), that is, an employer pays a higher basic wage than the wage that has been collectively agreed, covering all employees in the sector. This is called 'wage drift'.

Combining these factors, wages can reach considerably higher levels than those indicated in Table 6. For instance, in Slovenia, a social care worker with 10 years of experience and receiving various wage supplements would earn around €20,000 (81% of the average wage), a nurse €25,000 (101%) and a head nurse €35,700 (145%). The basic pay listed for Romania for social assistants can be up to RON 54,732 (99%) (€11,245), and for nurses up to RON 45,000 (81%) (€9,246). In Cyprus, carers in one of the three public residential LTC homes (the best-paying employer – see Table 6) can earn up to €26,460 (102%) after 12 years, including shift benefits. In France, the average earnings of private sector nurses and care workers are €27,037 (71%) and €32,037 (84%), respectively. In Hungary, in 2018, the average salary in the social

sector was HUF 3,024,000 (€8,511) (71%). In Sweden, female assistant nurses earn on average SEK 340,800 (€33,449) and men SEK 337,200 (€33,095) annually (SCB, 2019), which is well below the 2019 average salary for a single person (76% and 75%, respectively). It has been speculated that women are paid more on average in professions dominated by women, while the reverse may be true in male-dominated professions (Kommunal, 2016). Personal assistant carers earn on average SEK 324,000 (€31,800) (72%). In theory, in Lithuania the salary specified in Table 6 can reach a maximum €24,396 (204%) for a specialist with 10 years of experience, but workers in social services rarely receive this salary. In general, even with wage supplements and tenure-based increments, in practice, the wages listed in Table 6 rarely reach national average wages.

### Within-country heterogeneity

The average SES wage and the low-end basic pay data presented in the previous section mask within-country heterogeneity. This section discusses differences between LTC professions, the public and the private sector, residential and non-residential LTC and location. There are also other forms of heterogeneity, for instance between workers who are members of a trade union with a collective agreement and those who are not (for example, in Lithuania, since a 2018 agreement was implemented, trade union members receive a 15% higher salary than non-members, even if working for the same LTC organisation).

### Professions

The best-paid most commonly practised professions in the LTC sector include senior social workers, specialised nurses, physiotherapists, speech therapists and activity therapists. Carers, social carers and domestic LTC workers tend to receive the lowest pay, followed by assistant nurses. SES data show that personal care workers (ISCO-08 code 53) earn 97% of the average wage in LTC; they are paid less regardless of whether they work in residential care (94% of the average) or non-residential care (99%).

Overall, all of the salaries listed in Table 6 lie well below the national average earnings for the entire economy. Only four of them reach 85% of the average, and about three-quarters of them do not even reach 65% of the average. Even relatively well-paid LTC professions rarely receive more than 25% above average (with some exceptions, for example, managers of care homes or larger provider companies or physicians providing LTC services). For instance, in Malta, an 'advanced practice nurse' starts at €28,326, with annual increments of €640, capped at €32,170 (122%). Specialist nurses in Slovakia were paid an average of €1,293 gross per month in 2019, well over twice the lowest-paid LTC workers (carers and home care assistants for older people with disabilities: €562) but only still just above the national average of 106%.

To illustrate the variations between professions: in Greece, the basic salary specified in the private residential LTC collective agreement mentioned in Table 6 is highest for psychologists and speech and language therapists (€929 per

month) and social workers (€884) and lowest for assistant nurses, assistant cooks, stewards and social carers (€606) and unskilled workers (€605). For nurses, the basic salary is €682. In Luxembourg, where, along with the Netherlands, LTC workers' pay seems most favourable on average (see

section on 'Average earnings across Member States'), the annual salary for care workers in the LTC sector with 10 years of experience ranges from €45,017 (69% of the average) to €109,071 (168%). Some non-care professions are among both the best and the worst paid (Table 7).

**Table 7: Illustration of variations in wages by LTC profession, Luxembourg**

Profession	Annual gross salary, 10 years of experience (€)
Administrative, logistical, and technical, craft and manual professions, without qualifications	37,815
Social and family caregivers and qualified administrative, logistical and technical professions	45,017
Caregivers and life support professions, educators and administrative, logistical and technical professions, vocational skills certificate (CATP) level	54,535
Graduate educator and administrative professions, secondary school certificate level	68,684
Graduate nurses, administrative professions with an advanced technician's certificate (BTS), medical technical assistants, specialist nurses, midwives	76,916
Social workers, graduate educators, physiotherapists, speech therapists, psychomotor therapists, etc.	100,067
Administrative and socioeducational professions, MSc level	109,071

**Note:** Collective employment agreement for employees in the care and support sector and the social sector (CCT-SAS agreement).

**Sources:** Fédération des Hôpitaux Luxembourgeois (FHL) and Fédération COPAS

Although dependent on the level of specialisation, in some countries social workers are generally on a higher pay scale than nurses (Austria, Greece, Luxembourg), while in other countries the reverse is true (Estonia, Slovakia, Slovenia, Sweden). In Sweden, on average, nurses earn SEK 446,000 (€43,774) and social workers SEK 420,000 (€41,222) – both below national average earnings. In Austria, registered LTC nurses (assistant nurses earn less) are paid the same as certified social workers specialising in working with older people (€37,554), but non-specialist social workers earn more (€42,981) – both below national average earnings. In Estonia, the median monthly wage for social workers (€1,304) is below that for nurses (€1,506).

Wage data often exclude sections of the LTC workforce and more often concern publicly employed workers and workers covered by collective agreements. In particular, data often exclude domestic LTC workers, who tend to be on the lowest salaries (even if they receive additional in-kind compensation – see section on 'Live-in care').

For example, live-in carers in Bulgaria receive €200–300 per month. In Cyprus, the gross salary for a migrant domestic care worker is €460 per month (Civil Registry and Migration Department, 2020). These salaries are below the low-end salaries in other areas of the LTC sector, which are already well below national average salaries (Table 6). In Romania, earnings by home care workers (mainly domestic care workers employed by the household) are between RON 2,230 (€458) per month (the minimum wage) and RON 3,345 (€687) per month, depending on training and experience. In Germany, Greece, Italy and Spain, many undeclared domestic carers earn below the minimum amounts in Table 6, around €1,500, €400–700, €1,000–€1,200 and €600–€1,000 per month, respectively, for live-in carers. Filipino domestic carers in Malta are paid a gross salary of around €10,000 annually. Minimum official wages for domestic workers and those working for charitable institutions that provide residential LTC are regulated and are below €800 per month (Table 8).

**Table 8: Minimum pay for domestic workers and private non-profit residential LTC workers, Malta, 2019**

	Workers who are engaged by the:					
	Month and sleep in their employer’s house for > 16 nights in any month	Month and sleep in their employer’s house for < 17 nights in any month or not at all	Week and sleep in their employer’s house for > 3 nights in any week	Week and sleep in their employer’s house for < 4 nights in any week or not at all	Day	Hour
Minimum remuneration	€799.23/month	€782.94/month	€184.57/week	€182.82/week	€30.47/day	€4.57/hour
Hours	Max. 40, excluding breaks for meals and rest					
Overtime	1.5 times for hours over 8 in a day (when not living in) or > 40 hours/week					
Work on rest days/ during holidays	Double pay					
Statutory supplement	€135.10/6 months					
Weekly allowance	€121.16/6 months					

Source: DIER, 2020

**Public and private sectors**

In several Member States, wages in LTC are generally higher in the public sector than in the private sector (Austria, Cyprus, Czechia, Finland, Ireland, Poland, the UK). For instance, in Austria, employees of (regional) state-run care homes usually receive higher wages than those working in the private sector. The starting wage for a registered nurse in the Vienna Association of Hospitals (which runs nine care homes) is €2,668–3,291 per month, similar to that specified for a registered nurse with 10 years’ experience in the private sector collective agreement. In Finland, the salary for a ‘practical nurse’ working in a private residential LTC unit is €200 per month below that for a practical nurse in the public sector/municipalities; for nurses, the difference is on average €300 per month (Tehy, 2018; Local Government Employers KT, 2019). In England, in 2017, the median hourly pay for care workers directly employed by local authorities was GBP 9.80 (€11.00), compared with GBP 7.76 (€8.71) for those employed by independent providers. In Malta, wages in the private non-profit sector were generally lower than those in the public sector but in 2019 the church announced that employees of its homes providing elderly care would be paid the same as those in government-run homes providing elderly care (*Times of Malta*, 2019). Since 2017, the government has further mandated private contractors providing services to the Maltese government to apply specific minimum hourly wages in line with the public service collective agreement: €6.21 for carers, increasing to €6.89 in 2024 (DIER, 2017). In France, in non-profit residential elderly care, the average salary of a care assistant was €2,020 per month in the private sector and €2,189 per month in the public sector in 2015 (Ministry of Social Affairs and Health, 2019a); however, for personal care workers, the minimum wage in the private sector (€2,121 per month) was above that in the public sector (€2,020 per month). In some countries (Bulgaria, Lithuania), private sector LTC workers tend to

earn more than public sector workers. In Bulgaria, private sector LTC workers generally earn about twice as much as public sector workers. In Lithuania, in 2018, average gross monthly earnings of employees in social services (NACE codes 87 and 88) were €684 in the public sector and €724 in the private sector.

**Residential and non-residential LTC**

Residential LTC workers, more often than non-residential LTC workers, feel that they are not paid enough, given their efforts (EWCS 2015). However, home care workers tend to earn less than residential LTC workers (Tables 5 and 6). This is confirmed by national data. In Slovakia, ‘carers and home care assistants for older people with disabilities’ earned an average monthly wage of €562 (second quarter of 2019). Equivalent workers in residential LTC earned €766 monthly, over €200 per month more. However, wages for the first group of workers have increased more since 2013 than wages for the second group (80% versus 53%). In Czechia, average monthly wages for nurses and social services workers in residential LTC are CZK 24,365 (€922) (private) and CZK 27,548 (€1,043) (public), respectively. For outpatient care, field services and home-based care, average monthly earnings are lower both in the private sector (CZK 23,367, €884) and in the public sector (CZK 25,826, €978). In Poland, home care workers are paid less than workers in social care organisations, with residential LTC workers being paid even more. In Estonia, the median monthly wage of a care worker in residential LTC is €909 and in home care it is €740.

**Location**

Earnings can differ between regions and localities (including urban versus rural, and capital city versus non-capital city). For instance, the average earnings of social workers in Lithuania range from €813 in Utena District Municipality to €1,593 in Vilnius City Municipality. Those of individual care staff (assistant social workers, home help



workers, personal assistants) similarly show a large range (from €623 to €973).

Where pay differs by locality, it is generally higher in large cities. However, this difference may not outweigh the higher cost of living. In the UK, in 2018/2019, the Living Wage Foundation calculated that the hourly wage should be GBP 10.55 (€11.84) in London and GBP 9.00 (€10.10) across the rest of the UK to provide a decent standard of living ('real living wage'). In 2018, nearly half (43.4%) of all jobs in social care paid below these wages, nearly double the rate in the economy overall (22.6%). Overall, the social care sector employs 9.4% of all workers in the UK who are paid below the 'real living wage'.

### Minimum earnings

General (national/regional) minimum wages have an impact on salaries in LTC. Increases in the minimum wage tend to push up collectively agreed low-end wages if they are already above the minimum, and directly increase wages for LTC workers who are paid the minimum wage. For instance, in Portugal, the lowest salaries benefited from the minimum wage increase of around 30% from 2014 to 2020, after being frozen for three years (2012–2014). In Poland, national minimum wage increases have improved salaries for many care workers, with a particularly large increase from 2019 (PLN 2,250 (€502) per month) to 2020 (PLN 2,600 (€580) per month). The minimum basic salaries for many LTC professions lie below this, however, so this does not have an effect in practice (for example, PLN 24,738 (€5,517) per year for a 'carer for older people', 'qualified carer in social assistance home', 'medical caregiver' and 'physiotherapy technician', compared with a national minimum wage of PLN 33,852 (€7,550) per year). In Romania, home care worker salaries start from the minimum wage, which increased from RON 2,080 (€427) to RON 2,230 (€458) in 2020. In Germany, care workers not covered by a collective agreement must be paid at least the national minimum wage. In Hungary, entry-level pay for residential LTC nurses is set at the minimum wage (HUF 161,000 (€453) per month), plus an additional supplement for social workers of HUF 6,000 (€16.89), giving a total of HUF 167,000 (€470) (2020).

Minimum wages may differ between regions. In 2020, the minimum hourly wage for carers was set at €11.35 in western Germany and €10.85 in eastern Germany. For a 40-hour working week (with 53 calendar weeks and including paid holidays), this corresponds to about €24,000 and €23,000 per year, respectively. National minimum wages may also differ between professions. In Cyprus, the minimum wage for carers has been €10,440 since 2012; after six months of service this increases to €11,040. The private for-profit residential carer salary in Table 6 is based on this national minimum wage. The private non-profit residential carer salary is also based on the minimum wage but a 13th month is added as part of a collective agreement.

For many countries, salaries for several care professions in LTC are at the level of the minimum wage (for example, home care workers in Romania – see Table 6) or barely above it. For instance, in Portugal, wages for all

professions listed in Table 6 except for nurses are very close to the minimum wage (of €600 per month), with direct action assistants earning most (min. €622 starting salary, and €646 after 10 years). In Slovakia, in the second quarter of 2019, carers and home care assistants for older people with disabilities earned €42 above the national minimum wage of €520 per month. The national average wage is more than double (€1,215) and has shown a larger increase since 2013 (54% versus 36%).

Minimum rates and wages are not always respected. For instance, in Poland, while no data are available for LTC, in healthcare over 5,220 nurses were paid below the minimum basic wage set for June 2017 to July 2019 (Ministry of Health, 2019). In the UK, around 25,000 care workers were paid below the relevant minimum wage for their age in 2016, which equates to 2.4% of the social care workforce; this is one of the highest rates among the various sectors. The real extent of underpayment of the minimum wage may be far greater than this figure because of the combination of low hourly rates of pay and widespread non-payment of all working hours (Dromey and Hochlaf, 2016).

For home care, there is a specific aspect of pay that risks underpayment: the need to travel to the homes of care receivers. In the UK, in 2017, nearly two in three home care workers (63%) reported that they were paid only for contact time, not for travel between care users' homes (UNISON, 2019). This is despite clear guidance in the UK's 2014 Care Act that travel should be treated as working time (UK Government, 2018). In the Netherlands, the collective agreement for residential and home care stipulates that time spent travelling between clients should be counted as working time.

### LTC versus healthcare

Average earnings in healthcare are higher than those in LTC (see section on 'Average earnings across Member States'). However, when comparing sector averages, differences in the composition of the workforce in the different sectors should be taken into account; for example, there is a larger share of medical doctors (generally better paid) in healthcare. For instance, the higher wage in healthcare found in the SES analysis above reduces significantly for all countries for which data is non-confidential (Austria, Croatia, Hungary, the Netherlands, Norway, Romania, Slovenia, Spain, Sweden) if only personal care workers are considered (ISCO-08 code 53). The difference between healthcare and social service workers decreases by a factor of between 1.5 (Croatia) and 7.3 (Slovenia), and even reverses in Austria and the Netherlands, with personal care workers earning more on average in LTC than in healthcare. At the population-weighted EU27 level it also reverses: workers earn €2.02 more in healthcare than in social services, but personal carers earn €2.56 less in healthcare than in social services (residential LTC, non-residential care). While ISCO-08 categorisation and SES data complicate analysis for nurses, the situation can be expected to be similar for this group, partly due to differences in specialisation. For instance, in Germany, geriatric nurses (€1,700–2,200 monthly) are more often employed in LTC than better-paid certified health nurses

(€1,900–2,700 monthly) and paediatric nurses (€2,200–3,200 monthly).

Furthermore, care workers in healthcare may have undergone comparable training but have more experience. For instance, nurses often start working in LTC but move to healthcare as they gain more experience. In Cyprus, newly graduated nurses reportedly accept jobs in residential LTC with low pay to gain experience to work in hospitals. In addition, care workers in healthcare may have different skills. For example, in Luxembourg, COPAS, which represents care sector service providers, specifies that workers in the hospital sector require recently acquired skills adapted to new technologies and methods of care. As a result, older workers tend to remain in LTC, or even switch from the hospital sector to the LTC sector.

Comparison of data is further complicated by regional differences and differences between healthcare employers, even for similar nursing jobs. For instance, in Bulgaria, in state and large municipal hospitals, collectively agreed payment (present in healthcare, not in LTC), with a starting salary of around BGN 15,600 (€7,959) is respected or surpassed, but in many smaller municipal hospitals the average annual gross salary for nurses barely reaches BGN 10,800 (€5,510). In contrast, in regional hospitals and large hospitals in Sofia, annual salaries exceed BGN 24,000 (€12,245). In Spain, for nurses working in healthcare, annual earnings differ by region, being, for example, €23,000 in Madrid and €30,600 in the Basque Country (País Vasco). Such differences also apply to LTC (see section on ‘Within-country heterogeneity’). Healthcare employment may be concentrated in larger cities (in large hospitals) where wages may be higher.

Collective agreements setting wages for certain professions (for example, nurses) do not always distinguish between healthcare and LTC (Belgium, Ireland, Latvia, Sweden). In these countries, salaries in LTC and healthcare are guided by the same rules. This is also the case when wages are set by public regulations. For instance, in Austria, state-employed workers in (regional) state-run LTC homes and healthcare clinics fall under the same rules, with wages being determined by level of education. Therefore, a registered nurse in one of the Vienna Association hospitals earns the same as a registered nurse in one of its care homes, given the same level of education and seniority. In Slovenia, a nurse in LTC or healthcare earns about €1,129 per month, in line with the collective agreement for the healthcare and social protection sector, which covers both the public sector and the private sector. In Romania, the basic salary for nurses in Table 6 also applies to nurses in healthcare. In Hungary, for some LTC professions, such as nurses with health qualifications or doctors, wages are equal to those in healthcare; otherwise, wages are determined by the social sector or by national wage agreements.

Only a few cases were found where rules for LTC and healthcare differ for the same profession and level of experience. In Luxembourg, salaries in healthcare are higher than those in LTC. For instance, a nurse with 10 years’ experience earns 6% less in LTC under the collective employment agreement for employees in the care and

support sector and the social sector (CCT-SAS) than in healthcare under the collective employment agreement for employees working in hospital establishments (CCT-FHL): €76,916 versus €81,846 (2020). Working conditions are not only more favourable for healthcare in terms of earnings: the collective agreement covering LTC workers stipulates that a full-time working week in LTC is 40 hours per week, while that for the hospital sector sets the full-time working week at 38 hours (leave entitlements are also larger and breaks are mandated in the hospital sector). In Italy, a nurse working under the collective agreement for social cooperatives (which is the most common agreement in LTC) has a lower basic collective wage rate than a nurse in the public health system (working under the relevant collective agreement). In Poland, a doctor without a specialisation earns a basic monthly salary of at least PLN 4,410 (€984) when employed in healthcare, while in social assistance homes the minimum monthly salary is PLN 1,980 (€442). A nurse with a higher education qualification employed in healthcare receives at least PLN 3,066 (€684) per month, compared with a minimum monthly salary of PLN 1,920 (€428) in social assistance homes. In Bulgaria, the starting gross annual salary for medical professionals (for example, nurses, obstetricians, laboratory assistants) is around BGN 15,600 (€7,975), well above that for various LTC professions (Table 6).

In summary, healthcare appears to pay more than LTC. This can be partly explained by differences in the composition of the workforce, with more higher-paid professions and experienced workers in healthcare. The overall impression from the information gathered by the Network of Eurofound Correspondents is that the healthcare sector is often seen as a more attractive employer by care personnel. This is particularly relevant for nurses, who form an important share of both the LTC workforce and the healthcare workforce.

## Working time

The LTC sector scores relatively poorly for ‘working time quality’ (Figure 6). This is not because of the number of hours worked weekly. LTC workers rarely work more than 48 hours per week (EWCS 2015), probably because of the part-time nature of the work rather than more favourable regulations regarding working time. This section shows that low working time quality in the LTC sector results from the high incidence of atypical hours, shift work and irregular hours.

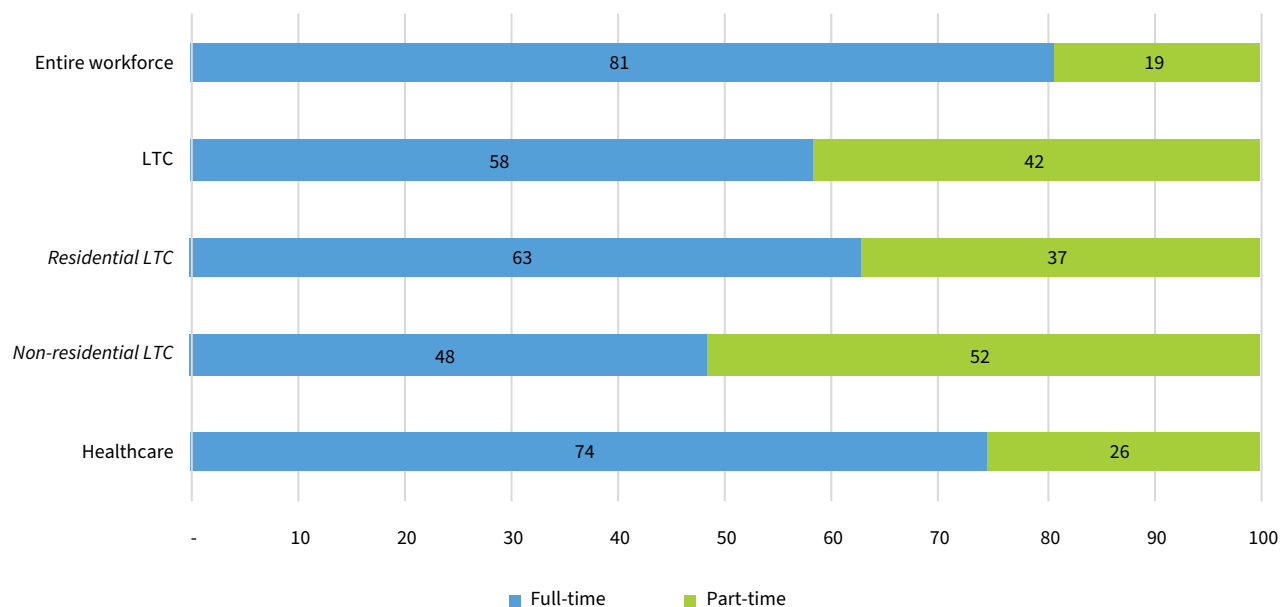
### More part-time work, but not all voluntary

In the EU27, 42% of the LTC workforce works part time, more than double the rate among the entire workforce (19%) and well above that for the healthcare sector (26%) (Figure 7). Part-time work is more common in non-residential LTC (52%) than in residential LTC (37%). The rate ranges from 5% or below in the six Member States with the lowest part-time rates in LTC (Croatia, Greece, Hungary, Portugal, Romania, Slovakia) to 40% or above in the six Member States with the highest part-time rates: 40% in France, 47% in Germany, 48% in Sweden, 55% in Austria, 62% in Belgium and 87% in the Netherlands. It

is particularly high in some subsectors. For instance, in France, 89% of home care workers work part time (Ministry of Social Affairs and Health, 2019a). Because of the high proportion of part-time workers, fewer LTC workers (28%) than workers overall (32%) report working over 10 hours

a day at least once per month (EWCS 2015). Because of the high proportion of part-time workers, fewer LTC workers (28%) than workers overall (32%) report working over 10 hours a day at least once per month (EWCS 2015).

**Figure 7: Full-time and part-time workers: LTC, healthcare and the entire workforce, EU27, 2019 (%)**

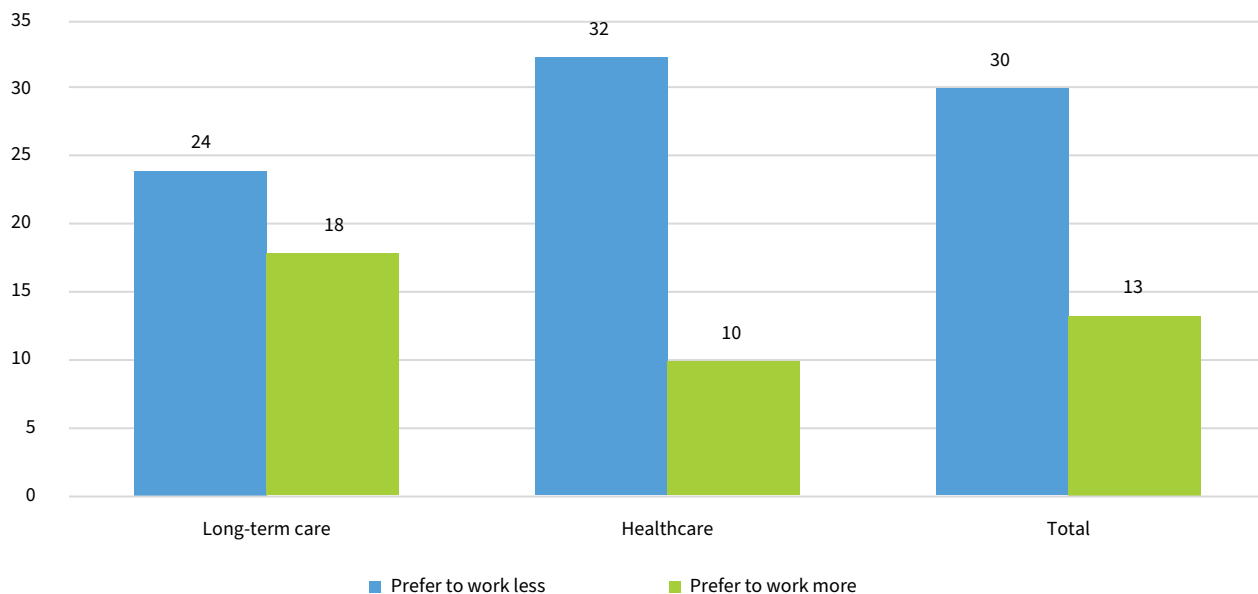


**Source:** Eurofound analysis of LFS extraction provided by Eurostat

A large proportion (58%) of LTC workers do not want to reduce their working hours, given that they need to earn an acceptable living (Figure 8). More LTC workers (18%) than healthcare workers (10%) or workers overall (13%) want to increase their hours. Among part-time workers in LTC, approximately one in three want to increase their working hours, as in the overall workforce. Among full-time LTC workers, 7% would like to increase their working

hours. However, there is limited potential for them to do so as, on average, they already work 38 hours per week. Among part-time workers, the potential is larger as, on average, they work 24 hours per week. Based on EWCS data, there appears to be significant potential for 13% of all workers in LTC to increase their working hours as they work part time and want to increase their working hours.

Figure 8: Preferences for working hours, EU27 and the UK, 2015 (%)

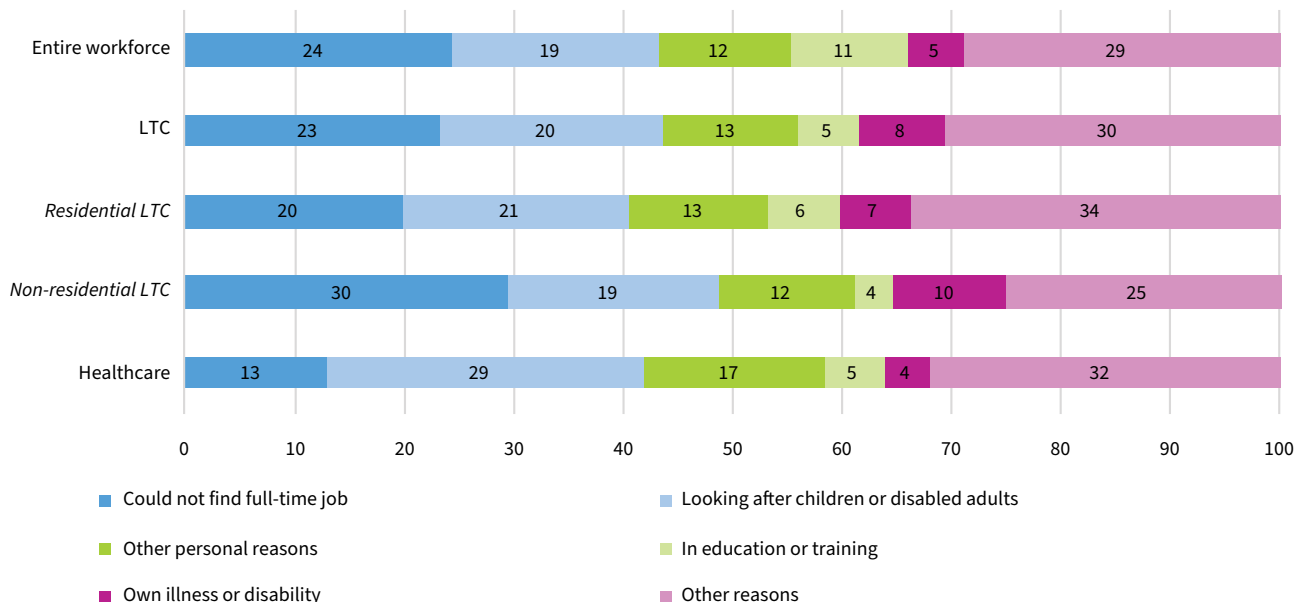


Source: Eurofound analysis of EWCS data

The reasons for working part time are similar in LTC and the entire workforce, but differ from those in healthcare (Figure 9). Most notably, in healthcare it is less common for people to work part time because they are unable to find a full-time job, and more common to work part time because they also spend time providing informal care (for

a child or for an adult with disabilities). Within LTC, there are differences between residential and non-residential LTC. In particular, a relatively high proportion of non-residential LTC workers work part time because they cannot find a full-time job.

Figure 9: Reasons for working part time: LTC, healthcare and the entire workforce, EU27, 2019 (%)



Source: Eurofound analysis of LFS extraction provided by Eurostat

As may be expected, the inability to find a full-time job as a reason for part-time work is uncommon in some countries that report staff shortages (see section on ‘Staff shortages’), with a proportion of 8% (Austria) or below

(Belgium, Luxembourg, the Netherlands) of part-time LTC workers unable to find full-time work in these countries. However, in other countries with staff shortages, the proportion is 10% or above (Denmark, Finland, France,

Germany, Poland, Slovakia, Sweden and the UK).<sup>8</sup> For the LTC sector as a whole, the proportion of part-time workers who cannot find a full-time job is 20% or above in Denmark, France and Sweden (along with many other countries where the LTC sector is less well developed and staff shortages are less problematic).

The proportion of workers with ‘other reasons’ for working part time is similar for the LTC sector as a whole and the entire EU workforce, and highest for residential LTC workers as they comprise a rather large share of total. Further research is needed to better understand these reasons.

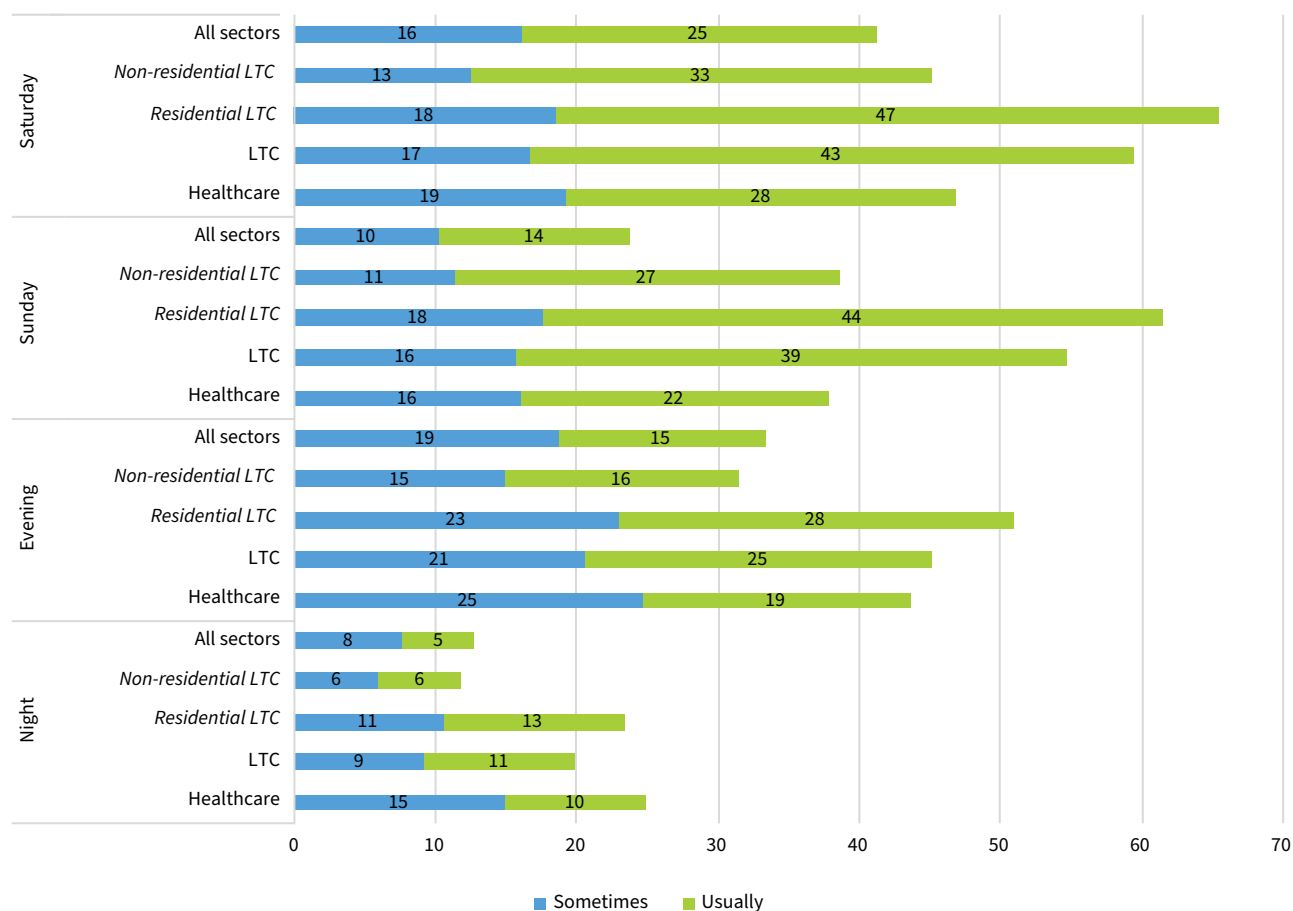
### More atypical working times, shift work and irregular working patterns

The effects of atypical working times and shift work on health have been well studied and include an increased

risk of accidents at work, cardiovascular disease and depression (Eurofound, 2017b).

Evening (45%), night (20%), Saturday (59%) and Sunday (55%) work are more common in LTC than in all sectors overall (33%, 13%, 41%, 24%, respectively) (Figure 10). LTC workers also more often report *usually* working at these times, rather than *sometimes* doing so. Furthermore, such work is more common in LTC than in healthcare. The exception is night work, which is slightly more common in healthcare. However, among those healthcare workers who work at night, 40% *usually* do so and 60% *sometimes* do so. Among healthcare workers who work at night, more report doing so *usually* (54%) and fewer *sometimes* (46%). Residential LTC has higher rates of evening (51%), night (23%), Saturday (65%) and Sunday (62%) work than non-residential LTC (31%, 12%, 45% and 39%, respectively). However, workers in both LTC subsectors are similarly likely to usually work at these times.

Figure 10: Evening, night, Saturday and Sunday work, EU27, 2019 (%)



**Note:** ‘No answer’ responses are excluded from the data. Differences in percentages are due to rounding.

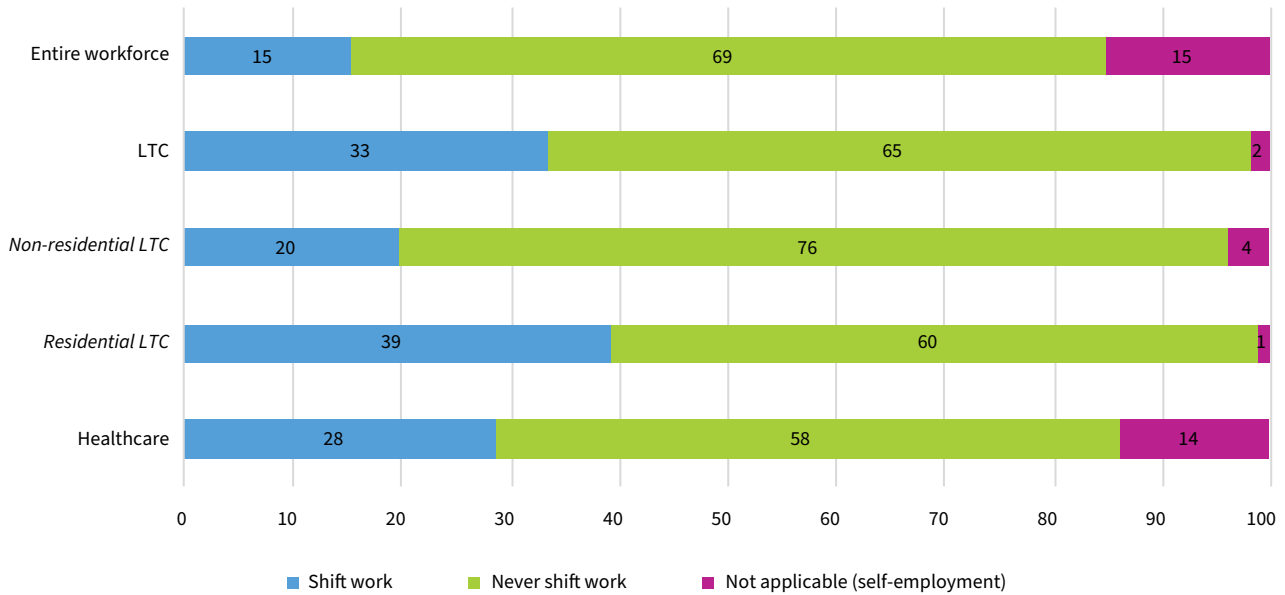
**Source:** Eurofound analysis of LFS extraction provided by Eurostat

<sup>8</sup> Analysis of an LFS extraction provided by Eurostat, excluding ‘no answer’ and ‘not applicable’ responses. Only countries with a large enough sample size are mentioned (respondents working part time in non-residential LTC). Point estimates are not provided as they are not sufficiently reliable.

One-third (33%) of LTC workers are involved in shift work, which is more than the proportion of healthcare workers (28%) and more than double the proportion of the entire

workforce (15%) who are involved in shift work (Figure 11). Shift work is more common in residential LTC (39%) than in non-residential LTC (20%).

Figure 11: Shift work, EU27, 2019 (%)



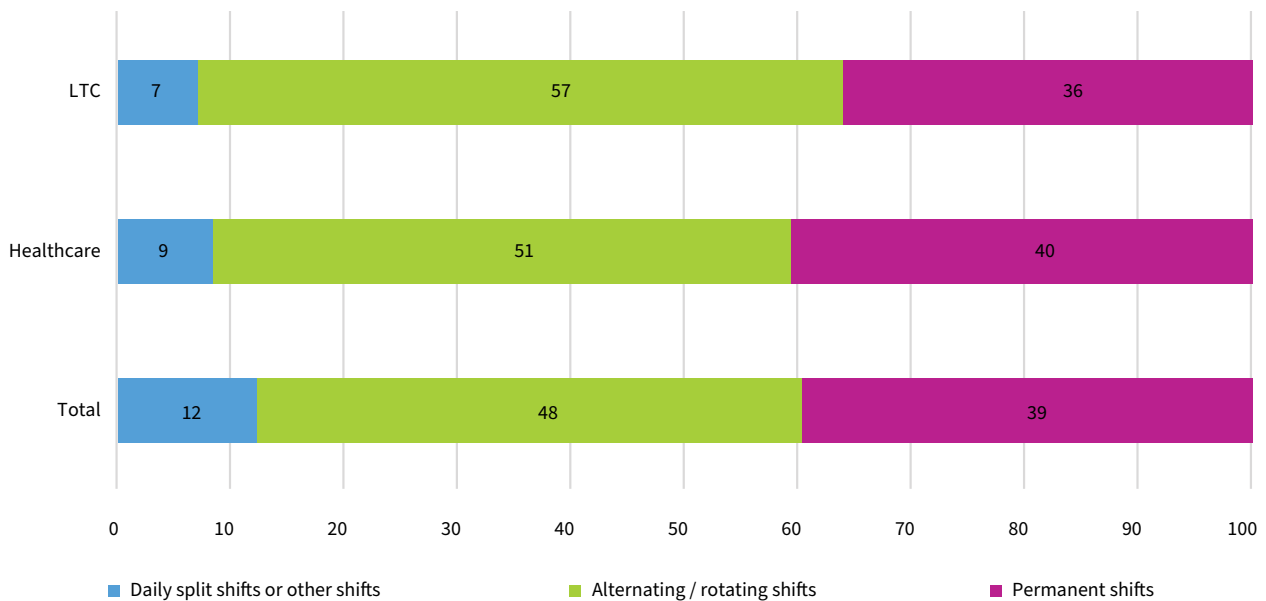
Note: 'No answer' responses are excluded from the data.

Source: Eurofound analysis of LFS extraction provided by Eurostat

EWCS data reveal more about the type of shift work. More irregular types of shifts (alternating/rotating shifts) are

particularly common in LTC: 57% of all shift work in LTC, 51% in healthcare and 48% in all sectors (Figure 12).

Figure 12: Shift work by type of work, EU27 and the UK, 2015 (%)



Source: Eurofound analysis of EWCS data



Almost two-thirds (64%) of LTC workers report having no say in their working time arrangements, which are set by the organisation with no possibility of changes (56% overall, 58% healthcare) (EWCS 2015). In addition, 66% had been requested to come into work at short notice in the year prior to the EWCS (47% in the healthcare sector and 39% overall), with 1% being requested to do so daily, 5% being requested to do so several times a week and 15% being requested to do so several times a month. This was more common among LTC workers who provide direct care and less common among supporting occupations. There was no difference between residential and non-residential LTC. In total, 43% of LTC workers indicated that they do not work the same number of days every week, compared with 34% in healthcare and 25% overall. In addition, the proportion of workers indicating that they do not work the same number of hours every week was slightly higher in LTC (41%) than overall (37%).

While these data present a general picture for residential and non-residential LTC, there are differences in working

patterns between the different types of LTC work and employers. For instance, in Bulgaria, private sector working hours are often more inconvenient.

### Work-life balance

Despite scoring lower for working time quality, LTC workers do not rate their work-life balance lower than average. About 29% of workers in LTC say that their working hours fit 'very well' with their family or social commitments (28% on average). However, this is only true for 17% of shift workers in LTC, compared with 40% of those who do not work shifts (Figure 13). In contrast to other sectors there is no difference between part-time and full-time workers in LTC in how they rate their work-life balance. This may indicate that full-time workers with work-life balance issues can shift relatively easily to part-time work in LTC. Overall, these findings suggest that the organisation of working time rather than the number of working hours is an important factor for work-life balance in LTC.

Figure 13: Work-life balance by sector: shift and part-time work, EU27 and the UK, 2015 (%)



**Note:** Workers reporting that their working hours fit in with family or social commitments outside work 'very well'.

**Source:** Eurofound analysis of EWCS data

LTC workers do not report working more often than average in their free time to meet work demands; 7% of LTC workers report that this happens at least several times a week, compared with 9% on average.

### Work intensity and environment

LTC rates negatively in terms of 'work intensity' and 'social environment'. This is linked to high levels of emotional demands and adverse social behaviour in the workplace, with many LTC workers having to deal directly with people other than their colleagues: 47% do this all the

time (compared with 30% in healthcare and 12% overall) and 15% do this almost all the time. Those who do not deal with people other than their colleagues more often are men and work in support professions, for example, as cooks, gardeners or office clerks. Nearly half of LTC workers visit people in their homes (61% of workers in non-residential LTC and 38% of workers in residential care). With respect to this issue, there may be differences in interpretation, especially among nurses in residential LTC, some of whom may see residential LTC homes as the home of the care receiver. Other nurses may see visiting users from room to room as visiting their homes, while others do not.

## High levels of emotional demands

Emotional demands are negatively linked to burnout, health and wellbeing (Eurofound, 2019b).

About 23% of workers in LTC report being in situations that are emotionally disturbing for three-quarters of the time or more. This is similar to the proportion of workers in healthcare who report this (22%), but lower than in the overall workforce (10%). Almost one-fifth (18%) of LTC workers report that their job requires them to hide their feelings all the time, compared with 13% in the overall workforce. Over one in five workers in LTC (22%) handle ‘angry clients, customers, patients, pupils, etc.’ almost all the time or all the time, more than in healthcare (18%) and twice as many as in the overall workforce (11%).

In addition to high levels of emotional demands, LTC workers’ high work intensity is driven by more often having frequent interruptions at work that are considered disruptive (27% compared with 16% overall), as well as rarely or never having enough time to get the job done (16% compared with 10% overall).

## Staff–user ratios

Staff–user ratios matter for quality of care and working conditions, and have consequences for staff needs (see section on ‘Staff shortages’). Standard ratios have been recommended or are legally required in some countries, or introducing them is part of the political discussion. They may vary by user needs (Cyprus, Malta), times of the day (Cyprus) and/or type of LTC job and setting (Finland), and can vary within a country (for example, by region as in the case of Austria), as follows.

- **Austria:** Four states (Upper Austria, Vienna, Styria, Vorarlberg) have set minimum personnel quotas for care homes (both private and public) based on LTC needs. In other states, varying targets have been defined. In Salzburg, no concrete numbers are provided (‘sufficient personnel’); in Carinthia, ‘target numbers’ are provided; in Tyrol, ‘nursing minutes’ are defined; and in Lower Austria ‘time that staff should be present’ is specified (Staflinger, 2016; Staflinger and Müller-Wipperfürth, 2019).

- **Cyprus:** The staff–user ratio stipulated by the Homes for the Elderly and Disabled Regulations (Regulations 213/2000) depends on the time of day: 07:00–19:00: 1 carer for 10 self-reliant or 5 non-self-reliant residents; 19:00–22:00: 1:15 and 1:7, respectively; and 22:00–07:00: 1:25 plus one on-call carer. A residential LTC provider needs to employ approximately one carer for every two residents to comply with these regulations.
- **Finland:** In intensive sheltered housing units and residential care, the staff–user ratio should be 0.5 nurses (including practical nurses, nurses and therapists, but excluding, for instance, cleaners and chefs) per user, with a planned increase to 0.7 in intensive sheltered housing units by August 2020, to be fully in force by 2023 (Ministry of Social Affairs and Health, 2019; Yle, 2019, 2020).
- **Malta:** The 2015 National Minimum Standards for Care Homes for Older People stipulate that the ratio of nurses to care workers should be based on the Barthel-20 index disability scale, with a minimum of one qualified registered nurse on duty during every shift.
- **Norway:** A 2017 proposal to introduce standard ratios has been discussed in parliament.
- **UK:** There is a general requirement to have sufficient staff to deliver care effectively, without referring to specific ratios.

The OECD Health Database provides information about user numbers and nurses and personal carers working in LTC, showing the staff–user ratios. In Table 9, these data are complemented with data gathered by the Network for Eurofound Correspondents. The OECD and many countries provide information about the number of staff per 100,000 population aged over 65 and/or 80 years. These data are excluded because they reflect the capacity of (access to) LTC in a country (even if LTC needs differ largely between countries for fixed age groups), rather than working conditions or the quality of care services that are provided. Staff–beds/places ratios are included as they appear to be more closely related to working conditions and possibly quality. The data should not be used for cross-country comparison; rather, they give a broad impression of staff–user ratios, and of the variety of and gaps in information.

Table 9: Staff–user ratios in LTC, 2017

Country	Staff–user ratio*	Sources and notes
AT	Home LTC: 0.13 (13,195.1/101,911) Residential LTC: 0.54 (34,697.6/64,281)	**
BE	Residential LTC: - public: 0.367 - private non-profit: 0.370 - private for-profit: 0.28	Rijksdienst voor Sociale Zekerheid (2017), ING and Probis (2018)
CY	Residential LTC: - public: about 1 - private non-profit: about 0.4 - private for-profit: about 0.3	
CZ (2018)	Residential LTC workers/beds: - weekly care centres and elderly care homes: 0.39 - homes for people with disabilities and special care homes: 0.47 - sheltered housing: 0.26 - LTC centres: 0.77	ÚZIS CR (2018), Ministry of Labour and Social Affairs (2019)
DE	Home LTC: 0.09 Residential LTC: 0.5	**
DK	Residential LTC: - day shift: 2.9 - evening shift: 6.3 - night shift: 20.4	VIVE (2017)
EE	Home LTC: 0.54 Residential LTC: 0.14	**
EL (2016)	Elderly care units: 0.41 (4,337/10,541)	Ministry of Labour and Social Affairs (2017)
FI	95% of intensive sheltered housing units in elderly care meet the recommended ratio (with few differences between the private and public sector) – see text above	Finnish Institute for Welfare and Health (2019)
HR	Residential LTC (0.32): - public: 0.34 (7,211/20,934) - private: 0.29 (5,000/17,000)	Ministry of Demography, Family, Youth and Social Policy (2018) and estimates provided by a private LTC employer
HU (2016)	Residential LTC (nurses): 0.26	Hungarian Central Statistical Office (2017)
LT (2018)	Elderly care homes: 1.52 Care homes for adults with disabilities: 1.65 Home help: 8.8	Lithuanian data for care homes for older people and care homes for adults with disabilities. Data for home care are from the National Audit Office of Lithuania (2015)

Country	Staff-user ratio*	Sources and notes
LU (2016)	Home LTC: 0.2 Residential LTC: 0.7 From 2008 to 2017, there was a decrease in the ratio of users to: - qualified professionals, from 3.29 to 2.90 - social and family caregivers and auxiliaries, from 19.45 to 13.61 - nurses, from 7.84 to 7.18 - care assistants, from 6.62 to 5.48 - educators, from 25.19 to 19.30	** Inspection générale de la sécurité sociale (2020)
LV (2018)	Home care (carers): 0.08 (0.3 in 2005, 0.14 in 2010, 1.25 in 2015) Residential LTC workers: 0.28	** Central Statistical Bureau of Latvia

**Notes:** Data refer to FTE jobs. \*Only mentioned if users or staff are other than those used for the OECD-based estimates (nurses and personal carers). \*\*Authors' own calculations based on 2019 OECD health data.

## Physical and psychological health effects of the working environment

### Physical risks

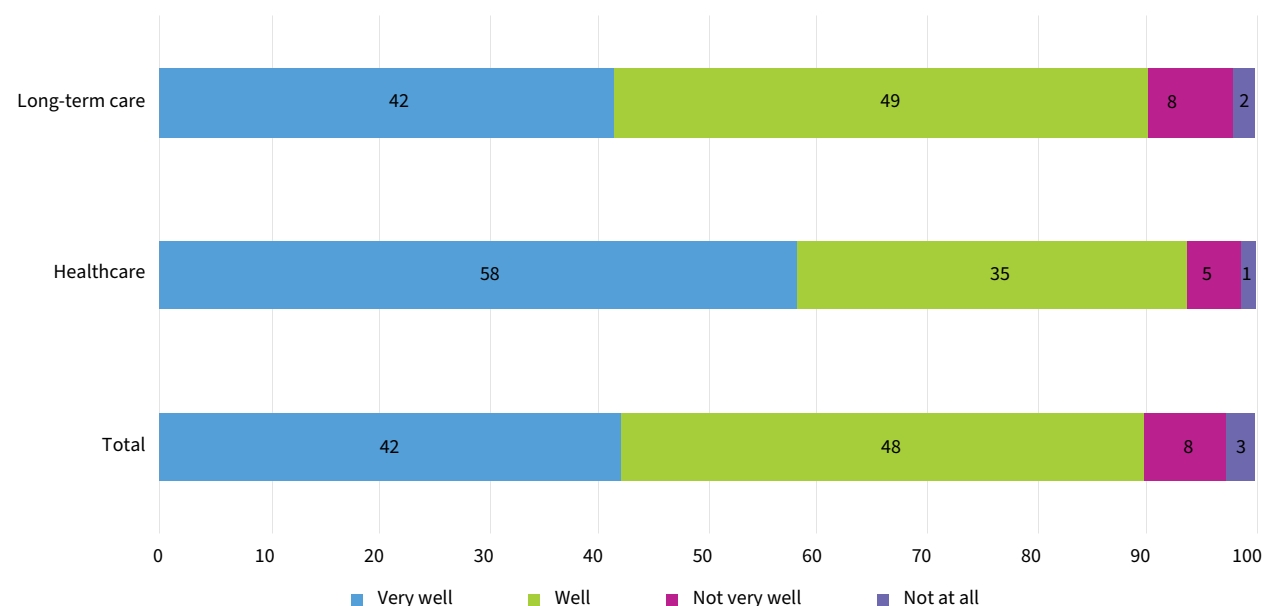
Workers in LTC facilities do not generally encounter the types of physical risks that are more common in industry, such as loud noises, extreme temperatures and vibrations from machines. The sector still scores below average for the job quality index 'physical environment' (see Figure 6). That is because LTC involves physical risks other than those common in industry, with 'lifting or moving people' being the most prevalent; 40% of LTC workers do this more than three-quarters of the time, almost double the proportion of workers in healthcare (23%) and eight times more than the average worker (5%). Furthermore, 23% of LTC workers handle or are in direct contact with materials

that can be infectious, such as waste, bodily fluids or laboratory materials, at least three-quarters of the time; this compares with 31% of workers in healthcare and 2% in all sectors.

Although the situation has changed during the COVID-19 pandemic, in 2015, over half (53%) of LTC workers had a job that required them to wear personal protective equipment. This is similar to the proportion of healthcare workers (53%) and lower than the proportion of workers in non-service sectors (61%) required to wear personal protective equipment. When asked whether personal protective equipment is always worn when required, nearly all workers in LTC (95%) responded 'yes'.

Workers in LTC do not feel 'very well' informed about the health and safety risks related to the performance of their job. This contrasts with healthcare, where many workers do feel 'very well' informed (Figure 14).

Figure 14: Feeling informed about health and safety, EU27 and the UK, 2015 (%)



Source: Eurofound analysis of EWCS data

## Social environment: Adverse social behaviour at alarming levels

Being exposed to adverse social behaviour at work can negatively affect the health and wellbeing of workers, contributing to anxiety, depression, sleeping problems and suicidal thoughts. A range of psychosomatic diseases are linked to adverse social behaviour, such as headaches, fatigue, cardiovascular disease and alcohol and drug abuse (Eurofound, 2015a).

The incidence of adverse social behaviour is alarmingly high in the LTC sector (Table 10). One in three LTC workers (33%) have been exposed to some type of adverse social behaviour at work (whether by users or colleagues), which is twice as high as the prevalence in the overall workforce (16%) and higher than in the healthcare sector (25%). Verbal abuse, unwanted sexual attention, physical

violence and sexual harassment are more common in residential LTC than in non-residential LTC. All of these forms of adverse social behaviour are experienced more frequently among LTC workers involved in direct care than among those in support professions.

## Impact on health and employment prospects in older age

In total, 37% of LTC workers think that their work negatively affects their health (compared with 29% in healthcare and 25% overall) (Figure 15). Almost two-fifths (38%) think that they will be unable to do their job until the age of 60 (or for five more years if they are aged over 60). This proportion is higher than that in healthcare (26%) and all sectors overall (27%). This could be partly explained by the high prevalence of shift work and adverse social behaviour and emotional demands.

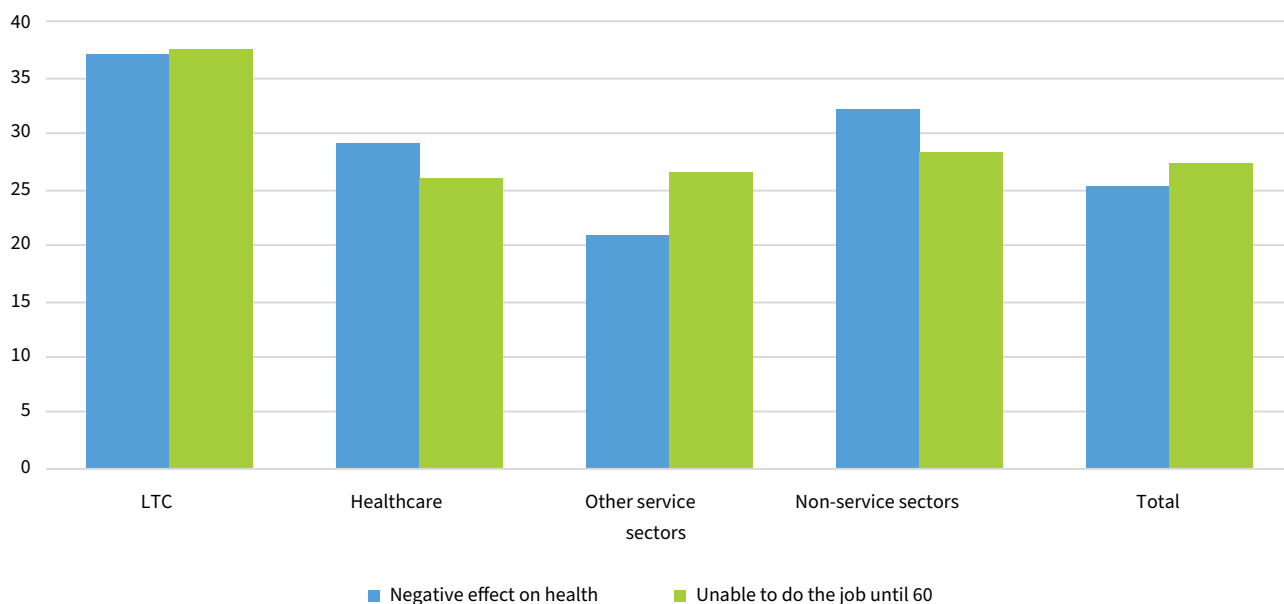
**Table 10: Prevalence of adverse social behaviour by sector, EU27 and the UK, 2015 (%)**

	Verbal abuse	Unwanted sexual attention	Threats	Humiliating behaviours	Physical violence	Sexual harassment	Bullying/harassment
LTC	<b>26</b>	<b>7</b>	<b>11</b>	<b>8</b>	<b>12</b>	<b>4</b>	<b>8</b>
Healthcare	18	2	6	8	5	1	9
Other service sectors	12	2	5	6	2	1	5
Non-service sectors	7	1	2	4	0	0	3
All sectors	<b>12</b>	<b>2</b>	<b>4</b>	<b>6</b>	<b>2</b>	<b>1</b>	<b>5</b>

**Note:** The prevalence of verbal abuse, unwanted sexual attention, threats and humiliating behaviours refers to the month prior to the survey, and the prevalence of physical violence, sexual harassment and bullying/harassment refers to the year prior to the survey.

**Source:** Eurofound analysis of EWCS data

Figure 15: Impact of the job on health, EU27 and the UK, 2015 (%)



Source: Eurofound analysis of EWCS data

## Skills development: More training, and more need for training

Almost three-fifths (58%) of LTC workers received training that was paid for or provided by their employer, equal to the proportion in healthcare, but well above that in all sectors (38%). LTC workers are more likely than the average worker to receive training, even after controlling for age, gender, part-time employment status and country. The higher training rate in LTC may be due to (legal) requirements for training, that is, the need to keep up with the latest developments.

Despite the relatively high rate of training, 24% of LTC workers felt that they ‘need further training to cope well with duties’ (22% in healthcare, 15% overall). Younger people were overrepresented in this category, as were those who mostly provide direct care (compared with those in support professions). This could be because of the high demands on these workers. New entrants might also need training to acquire the necessary skills; so possibly higher rates of new entrants in the expanding LTC sector may be another reason for the high training rate. People who have received training are also more likely to say that they need further training. Among LTC workers, 53% stated that their ‘present skills correspond well with their duties’ and another 23% stated that they ‘have the skills to cope with more demanding duties’. These rates are similar

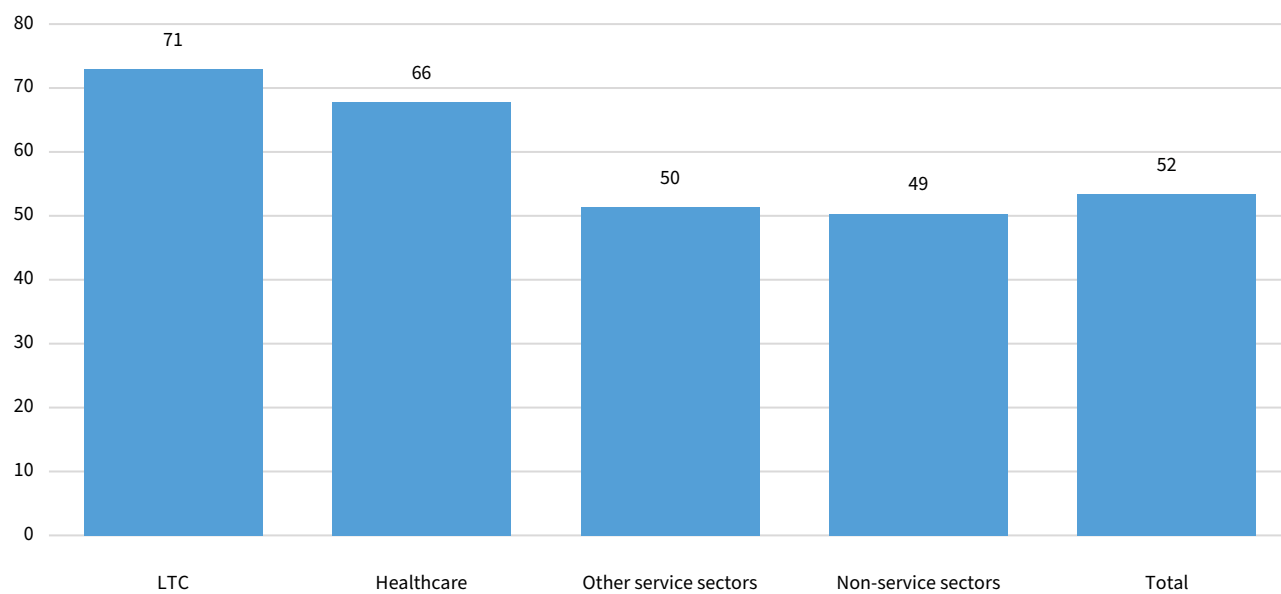
to those in healthcare (54% and 24%, respectively), but below those in the economy as a whole (57% and 28%, respectively).

LTC professions do not always require formal qualifications. This can be seen from the various wage categories in LTC for untrained workers (for example, Italy: ‘assisting a non-self-sufficient person, not trained’ in the household services agreement; Denmark: ‘social and health professional, no professional training’; see Table 6). Another example can be seen in the general social service staff in Bulgaria (orderlies, hygienists, kitchen workers, laundry and ironing staff); in contrast, formal qualifications are required for managers, occupational therapists, psychologists, social workers and medical professionals (doctors, nurses, paramedics, physiotherapists) in LTC.

## Usefulness of the work

In total, 71% of LTC workers indicated that they always feel that they are doing useful work. This compares with 66% in healthcare, 50% in other service sectors and 49% in non-service sectors (Figure 16). National evidence confirms that ‘the opportunity to help people’ is a key motivator (PwC, 2019). When asked whether their job gives them the feeling of work well done, the responses did not differ much across the sectors.



**Figure 16: Usefulness of the work, EU27 and the UK, 2015 (%)**

**Note:** Percentages replying 'always' to the following statement: 'You have the feeling of doing useful work.'

**Source:** Eurofound analysis of EWCS data



## 4 Collective bargaining

Table 11 presents an overview of collective bargaining in LTC. Only a few Member States cover close to 100% of the LTC workforce through collective agreements (Austria, Belgium, Denmark, France, Luxembourg, the Netherlands, Slovenia, Spain). These estimates may, however, be somewhat deceptive, in particular because domestic LTC workers, who form a considerable section of LTC workers, are usually excluded (especially in Spain). In Finland and Italy, carers employed by households are covered

by a collective agreement; however, in both cases large sections of this group are left uncovered and conditions are not always respected.

Agreements are usually valid for periods ranging from two years (for example, Luxembourg: CCT-SAS, from 2017 to 2019) to four years (for example, Croatia: collective agreement for the social welfare sector, from 2018 to 2022), but may run for up to eight years (public service agreement in Malta).

**Table 11: Collective agreements in LTC and coverage of collective bargaining, EU27 and the UK, 2019/2020**

Country	Collective agreements in LTC	Estimated coverage*
AT	Regional, single-employer and specific types of care home (confessional) collective agreements. Largest: private social and healthcare sector agreement (SWÖ KV: health and social services, child and youth care, psychosocial work, work with people with disabilities, active labour market services)	Residential: > 95% Non-residential: > 95%
BE	Private sector: national-level negotiations, with possible deviations at the company level (main 'joint committees' for LTC: 330, 318, 319, 331) Public sector: tripartite protocol agreements (less binding than private sector agreements), for example, negotiated by the Consultation Committee on Welfare, Public Health and Family Largest: 330, including also hospital nurses	Residential: 100% Non-residential: 100%
BG	Only for the public sector	Residential: 25–27% Non-residential: 25–27%
CY	Public sector: all employees covered by collectively agreed terms of employment, implemented as regulations Private non-profit sector: employees mostly covered Private for-profit sector: < 10% covered (by a single-employer agreement). Providers may conclude a symbolic collective agreement to apply for permission to recruit personnel from third countries, granted by the Ministry of Labour to employers who adhere to collective bargaining and cannot find personnel in Cyprus. A multi-employer agreement (around 40 providers) ended in 2014.	Residential: 40% Non-residential: 20%
CZ	Individual organisation-level agreements, negotiated with the Trade Union of Health Service and Social Care in Czechia (Odborový svaz zdravotnictví a sociální péče České republiky, OSZSP ČR). No higher-level collective agreement has been put in place in LTC (nor in the health and social services sector as a whole). Most collective agreements are negotiated by the above-mentioned trade union member of the largest trade union confederation (Českomoravská konfederace odborových svazů, ČMKOS). Other confederations and independent trade unions and organisations are also active.	20–40%
DE	Public sector collective agreement (TVöD-B), including the United Services Trade Union (ver.di), Confederation of Municipal Employers' Associations (VKA) and the federal government Private non-profit (church) sector: based on a private company agreement or negotiated individually; church employment contract guidelines (AVR-K) apply Other private sector: company or individual agreements. After implementation of the 2019 law for better wages in care (Pflegelöhneverbesserungsgesetz), negotiations on a comprehensive collective bargaining agreement in care began, which may become nationally binding.	About one-third** Residential: 10%

Country	Collective agreements in LTC	Estimated coverage*
DK	Sector-level collective agreements. Largest for LTC: social and health professionals. The entire public sector is covered. The largest private service provider (OK-Fonden with approximately 2,000 employees) is also covered by an agreement similar to that in the public sector. Very few small private providers are uncovered.	Residential: almost 100% Non-residential: almost 100%
EE	Few collective agreements; all at organisation level (one private sector agreement was identified for a large residential LTC provider)	7%**
EL	Public sector: no collective agreements, as working conditions are set by law, following social dialogue limited to issues such as working time, training, health and safety, and social insurance Private sector: until 2015 there was a sector-level agreement for 50,000 employee members (15–20% of all private residential elderly care employees) of the first-level unions of the Federation of Private Health Sector Workers of Greece (OSNIE), employed in the 120 residential care homes that are members of the Greek Care Homes Association (PEMFI). In 2017, ratification was imposed as no agreement was reached.	Around 5%
ES	Coexistence of sectoral agreements at regional, local and company levels. Largest: national agreement for care centres and services for people with disabilities (200,000 workers)	100%
FI	Municipalities: general collective agreement for municipal employees Private sector: social services agreement (Yksityisen sosiaalipalvelualan työehtosopimus 2018–2020), which also covers non-signatory organisations. Personal care assistants (supporting people with disabilities to live on their own terms): own collective agreement, covering about one in four employers (unknown proportion of employees)	80–90%**
FR	Public sector: all LTC workers are covered by a public status, mainly as local government employees, but also as public hospital employees Private sector: main agreement is the national collective labour agreement for homes and services for people with disabilities, covering all social services. Other agreements apply and, through the extension of the collective agreements mechanism, it can be considered that about 100% of the workforce is covered by a collective agreement.	About 100%
HR	Public sector: all employees covered. Largest agreement in LTC: social welfare sector Private sector: few collective agreements. Employers with over 20 employees have to establish employment rules in consultation with the workers' council or trade union representative.	Residential: 60% Non-residential: 75%
HU	Public sector: conditions set by a government decree rather than by collective agreements Private sector: some collective agreements. No independent agreements between employers, employees and/or the government in LTC.	Residential: 48% Non-residential: 6%
IE	More in the public sector than the private sector. Multi-union negotiations have somewhat recovered since the recession, for nurses in particular. Absent in home care.	Residential: 60–80% Non-residential: 40–60%
IT	Public sector: all covered by a general national collective agreement Private sector (providing contracted-out social services to municipalities): different collective agreements are applied to companies and cooperatives affiliated to the various employers' associations that have signed national agreements. Household services collective agreement.	Residential: public 100%, private 75%/80% Non-residential: public 100%, private 75%/80%
LT	Mainly restricted to the public sector. Five trade unions have signed an updated sectoral agreement for almost 2,000 members in 49 social service establishments. Private sector: agreement between employer and employees	20–30%**
LU	A collective agreement, with four employer federations covering the entire LTC sector, ran from 2017 to 2019 (care and social care – CCT-SAS). A new agreement is being prepared, covering almost all LTC workers.	Residential: 100% Non-residential: 100%
LV	Collective agreement covers all services provided by the national government (residential care)	Residential: over 40% Non-residential: 0–10%

Country	Collective agreements in LTC	Estimated coverage*
MT	<p>Public sector: public service collective agreement, as well as entities with their own agreements. Sectoral agreements for various public healthcare grades: the General Workers' Union (GWU) and UHM Voice of the Workers cover nursing aides, health assistants and care workers in hospitals and residential LTC. The Malta Union of Midwives and Nurses (MUMN) signed an agreement in 2018 covering nurses in public establishments.</p> <p>Private sector: no sectoral agreements, but some employers (churches and other institutions) have agreements with unions</p> <p>For-profit sector: no agreements</p>	<p>Residential: 40-60%</p> <p>Non-residential: &lt; 1%</p>
NL	Sector-level agreements: most LTC workers are covered by a 'nursing homes and home care' agreement (others by agreements in 'disability care', 'mental healthcare', 'youth care', 'social work, welfare and social services')	<p>Residential: 100%</p> <p>Non-residential: 100%</p>
PL	Few agreements involving more than one organisation: in social assistance facilities managed by Częstochowa municipality, Międzyrzec region and Lubliniec region	< 1%
PT	<p>Public sector: no collective agreements, regulations set by the government after bargaining rounds</p> <p>Private sector: national collective agreements (for all social services) between trade unions and groups of private institutions of social solidarity (IPSS); and between trade unions and single institution/IPSS, equivalent to company agreements. Largest agreement: covering around 3,000 employers and 10,000 employees – encompassing education, cultural and social activities, health, healthcare and social care – CNIS/FEPCES (National Confederation of Solidarity Institutions/Portuguese Federation of Trade and Services Workers Unions), CNIS/FNSTFPS (National Confederation of Solidarity Institutions/National Federation of Public and Social Services Workers' Unions)</p>	72%**
RO	<p>No collective agreements at sector level or for a group of units</p> <p>Public sector: last agreement was valid for the period 2017–2018 for a group of units in the social services sector, including LTC</p> <p>Private sector: no collective agreements; mainly small employers (&lt; 15 employees)</p>	0%
SE	Largest collective agreement between the trade union Kommunal and the Swedish Association of Local Authorities and Regions. Three other large agreements and three smaller agreements. Not covered by agreements: mainly small private companies, the self-employed, and personal carers employed by care receivers.	<p>73%**</p> <p>Residential: 80–90%</p>
SI	Public and private sectors: all covered by an agreement for the healthcare and social care sector (Kolektivna pogodba za dejavnost zdravstva in socialnega varstva Slovenije), including employees with open-ended, fixed-term and part-time employment contracts and apprentices. There are sector-specific trade unions, such as the Trade Union of Health and Social Care of Slovenia (SZSSS).	<p>Residential: 100%</p> <p>Non-residential: 100%</p>
SK	Largest (framework) agreement: multi-employer collective agreement for public services, signed by central government and eight regional governments as employer representatives	49%**
UK	<p>Public sector: most social care workers covered by collective bargaining, including home care workers employed by local authorities</p> <p>Private sector: collective bargaining rare and occurs at the level of the employer or workplace (20% of care workers and 21% of senior care workers are members of a trade union or staff association, about average for the economy (21%), but below average for healthcare, where 83% of nurses are members)</p>	<p>Residential: 15%</p> <p>Non-residential: 32%</p>

**Notes:** 100% should be interpreted as 'close to 100%' (for example, the actual value may be 99.6%); small sections of the workforce may still not be covered. Undeclared work is excluded (as is sometimes declared domestic LTC); for example, the many undeclared live-in care workers in Italy and Spain are excluded. \*Estimated proportion of workers covered by collective bargaining (both multi-employer bargaining and single-employer bargaining), largely based on the 2020 Network of Eurofound Correspondents' input regarding the representativeness of trade unions and employer organisations in the social services sector, with updates from the Network of Eurofound Correspondents for this report, and rough expert opinions where data were lacking. \*\*Includes all social services (that is, also NACE code 88.91).

**Source:** Based mainly on input from the Network of Eurofound Correspondents.

Two Member States (Luxembourg and the Netherlands) have agreements specifically for (large sections of) the LTC sector (Finland also has such agreements, but only for the private sector). Often, however, LTC falls under agreements that also cover healthcare. For instance, in Slovenia, both public and private sector LTC workers are covered by the healthcare and social protection sector. In Denmark, the largest agreement in LTC is that for social and health professionals. There may also be an even broader agreement covering all public sector workers, including public LTC workers. In both cases, collective agreements are not specifically for LTC. However, collective agreements usually specify conditions for LTC-specific professions. In Ireland, for instance, LTC is included in the public health system, but certain professions are more likely to be found in the LTC sector (for example, home carers). In Belgium, most of the LTC sector falls under Agreement JC330, which includes private and psychiatric hospitals, elderly care, home care, revalidation centres and sheltered living. LTC is such a significant and specific part of this agreement that, in practice, the agreement largely covers LTC only.

Sometimes, only those employees who are members of the trade union that took part in the agreement are covered (Greece, Lithuania), so working conditions and wages can differ between members and non-members working for the same LTC service provider.

The coverage of collective bargaining seems to be higher in residential LTC in some countries (Cyprus, Hungary, Sweden) and in non-residential LTC in other countries (Croatia, Germany, the UK) (Table 11).

Collective bargaining is sometimes restricted to public sector LTC (Estonia, Latvia), is sometimes more prominent in the public sector (Malta, Sweden) or absent or very rare in both public and private LTC (Czechia, Greece, Poland). While in some countries collective agreements cover the private sector fully or partially (Finland, the Netherlands), in most countries private sector agreement is reached mainly at the level of individual organisations

or individually between the employee and the employer. Within the private sector, collective agreements tend to be more common in the non-profit sector than in the for-profit sector (Malta, Portugal). A service may be publicly financed or contracted, but that does not mean that workers are covered by any public collective agreement that may exist. For instance, in Finland, if municipalities buy services from a private company, the collective agreement that covers the employees is that of the private sector. In countries with a voluntary industrial relations system, where formal collective arrangements are absent, public sector agreements influence the rest of the sector (for example, Ireland).

In some countries, working conditions in the public LTC sector are set by government decisions (Lithuania, Poland, Portugal, regional state-run care homes in Austria), sometimes with input from social partners (Portugal). Collective agreements may exist as add-ons to such decisions (Croatia, Latvia, Malta). For instance, in Malta, nurses, carers and home workers are protected by Work Regulation Orders, which regulate minimum conditions in different sectors (see section on 'Earnings').

Collective agreements can be more common in healthcare. For instance, in Estonia, a sector-level collective agreement in the healthcare sector also covers nurses and carers. However, it covers only those employees in state-financed organisations (which may be privately subcontracted) and thus working in healthcare (financed through the Estonian Health Insurance Fund). This excludes nurses and care workers in social services (the majority of the LTC workforce). Another example is the UK, where all public healthcare employees are covered by a collective agreement, but not in LTC. However, the opposite may also be the case, with some agreements identified for LTC but none for healthcare (Poland). Compared with childcare, coverage is sometimes considerably lower in LTC (Hungary and Ireland, also residential LTC in Croatia) or equivalent (Denmark and Slovenia, also non-residential LTC in Croatia). Coverage is lower in childcare than in LTC in Austria and the UK.



# 5 Policies aimed at the long-term care workforce

## Policies to make the sector more attractive

The focus of this chapter is on the types of measures that have been implemented to make the sector more attractive (rather than on the target groups of these measures): information campaigns, initiatives to reduce barriers, and policies to improve education and training and working conditions. It maps initiatives and policies that emerged from the Network of Eurofound Correspondents, not always focusing specifically on the LTC workforce, but on nursing staff in general (Ireland, Malta), social service workers (Lithuania) and the social and healthcare workforce (Denmark).

### Information campaigns

#### LTC promotion and information campaigns

Some countries have launched campaigns to promote and inform about care (Belgium, Denmark, the Netherlands) and nursing (Malta) professions. In some campaigns, current staff act as ‘care ambassadors’ (Belgium, the Netherlands, the UK), talking about their experiences at meetings with students, teachers or staff in work centres or featured in TV and cinema advertisements and on billboards. Among participants in the ‘I Care’ ambassadors initiative in England (UK), 35% were more interested in a career in social care after an ambassador event (Skills for Care, 2019).

#### Addressing stereotypes about LTC users and LTC work

It has been suggested that addressing the negative stereotypes that society holds about older people and people with disabilities and LTC workers would help to make the sector more attractive. For instance, along with multiple other measures to attract LTC workers, a national communication campaign to change the perspectives of society on older people and LTC professions was proposed in France (Ministry of Social Affairs and Health, 2019b). Several campaigns also aim to tackle gender stereotypes to increase recruitment among men (OECD, 2020).

### Initiatives to reduce barriers

#### Proactive recruitment

Proactive recruitment is understood here to be the facilitation of ready-made packages to overcome specific barriers to employment (going beyond informing). Proactive recruitment initiatives may concern recruitment abroad by governments, offering packages that include, for instance, language training. In 2019, Germany established a specialist agency for skilled labour in health and care occupations, DeFa (Deutsche Fachkräfteagentur für Gesundheits- und Pflegeberufe). It is the first point of

contact for health and care providers intending to recruit international skilled staff, and facilitates visa applications and the recognition of professional qualifications and work permits (the service costs €350 per case). It also organises the selection of applicants and offers language courses (Federal Ministry of Health, 2019).

Proactive recruitment may also include work-to-work arrangements, in which LTC providers recruit workers at risk of redundancy. For instance, amid redundancies in the context of the COVID-19 crisis, the airline KLM and the care organisation Actiz have enabled airline personnel (mostly flight attendants) to switch to a career in LTC. Airline personnel are given a job guarantee, free professional nursing education and a similar salary to that which they received in their previous role (NOS, 2020).

#### Reducing legal barriers

Luxembourg has dropped the requirement to be fluent in Luxembourgish to work in LTC (committing to learning Luxembourgish is sufficient). Regulations have also been adjusted to facilitate working after the statutory pension age (Eurofound, 2012).

### Policies to improve education and training

#### Increasing the capacity of existing programmes

Reforms to increase the number of training and education courses available in Malta include setting up partnerships with universities to deliver courses and removing the student cap on nursing places. Denmark is investing in more tutors in social and health schools during the period 2019–2021 and is expanding the geographical coverage of education centres providing health and social care education. In both countries, grants and scholarships available for nursing, health and social care students have also been increased.

#### Establishing new programmes

Establishing specialised training and education courses specifically aimed at LTC not only increases the potential pool of qualified recruits but can also improve the image of the sector, its operational management and career progression opportunities. In Norway, as part of the Knowledge Promotion reform of 2006, the government established a training programme for healthcare assistants (*helsefagarbeider*) to stimulate employment in LTC and related services. Malta has established programmes leading to the accreditation of professional experience and qualifications obtained abroad. This includes courses bridging the gap between qualifications obtained abroad and requirements in Malta. Since 2017, the University of Malta has offered a bachelor’s degree in nursing, specialising in elderly care. The course aims to target people with a nursing diploma.

New programmes may also involve tailor-made courses targeted at specific groups. In Romania, several NGOs have provided state-accredited home care courses and the Romanian national agency for employment organises free vocational training for the unemployed. Between January and December 2019, 370 people attended the home care courses. In Sweden, assistant nurse training programmes are designed to provide immigrants and refugees with integrated vocational and language training (for example, the YFI programme in Stockholm). A fast-track training course has been introduced to facilitate the early integration of migrants into the labour market. In the Netherlands, refugees are similarly targeted.

### Internships, mentorships and traineeships

Denmark has increased the number of traineeships in health and social care, and produced internship guidance (information material for internship outreach work, to enable better dialogue between schools and those providing internships), for the period 2019–2022. Investment in internships was combined with the establishment of regional partnerships (also in the Netherlands).

### Vocational training

An example of training offered to current staff comes from Sweden, where the largest private care provider (Ambea) offers skills development training and coaching in disability care, social services and elderly care. One of Ambea's upskilling courses is the Dementia Academy. Training takes place over three days and provides tools to those working with older people suffering from dementia. The Greek Association of Alzheimer's Disease and Related Disorders in Greece offers carers living outside Thessaloniki and those who cannot attend meetings because of patient care the opportunity to participate in online support groups. Participation in the group is free and carers in provincial cities can interact and exchange views.

### Policies to improve working conditions

In Germany, a law that came into effect in 2019 to improve working conditions in the care sector (Pflegerpersonal-Stärkungsgesetz) promotes collectively agreed pay standards in care and seeks to improve work-life balance schemes and occupational health and safety measures. In recent years, wages in Hungary have increased significantly in the social sector, and the harmonisation of wages across similar jobs in health and social care has been discussed. In addition, an extra day off work has been introduced for workers across the whole social sector (Social Work Day).

### Policies to combat undeclared work

Public policies consider several paths to combat undeclared work (Eurofound, 2013), combining preventive measures (developing mechanisms for declaring work) and sanctions (controls and fines).

### Making declared work more attractive for all

Undeclared work in LTC is uncommon in countries where care is subsidised and subsidies are conditional on transparent provision and use of care services; not declaring care work means that the LTC user or the organisation does not receive government compensation (Luxembourg, the Netherlands). For instance, in Denmark, the 1993 'home service scheme' was key in tackling undeclared work in home care. Home service recipients receive 50% of the invoiced amount, but only if the provider is included in the home service scheme by the Danish Business Authority. In Cyprus, recipients of care benefits from the 'guaranteed minimum income scheme' are obliged to present to the authorities a care service agreement between the care receiver and the care provider, who can be employed through an organisation or who can be self-employed.

It is not just a question of how well a system is funded, but also of how it is organised. For instance, without strict requirements on the use of cash benefits, these benefits are frequently used to recruit domestic workers, including for undeclared work (for example, Cyprus, Germany, Italy, Latvia, Lithuania, Romania; see also ESPN, 2018b).

Some countries have devised voucher schemes, offering vouchers that can only be used to purchase declared work, with social protection for the carer. To reduce the incidence of undeclared work, Belgium has introduced vouchers for domestic services. In 2020, these vouchers cost €9 for one hour, reduced to €7.20 through tax benefits. Workers paid with the vouchers are insured. Services that can be paid for with the vouchers include cleaning, ironing, washing, mending, food preparation, transport of people with reduced mobility and food shopping. Elderly (and child) care activities are excluded but the high take-up of vouchers among older people suggests that they provide the needed support, mostly for IADLs, rather than ADLs. In total, 22% of Belgian households made use of the service vouchers in 2016 (and this rate has probably increased since). Over one-quarter of users (27%) said that they used them because they were unable to do the tasks themselves (older people and people with medical issues) (Goffin et al, 2018).

Providing a clear and user-friendly process for declaring LTC work, in particular if there are some tangible benefits in doing so in addition to legalisation of the situation (for example, in terms of social protection and insurance), can also reduce the incidence of undeclared work, even if there are costs involved. In Austria, undeclared work was very common among live-in carers but became virtually non-existent after a 2007 law was passed that provided an easy and affordable way to declare home care; however, the social protection offered to live-in carers remains limited. Since 2015 in Slovenia, in an effort to address undeclared work, employers of care workers (and other 'personal supplementary workers') have had to register the workers and purchase monthly vouchers (€9.80 in 2020) that cover protection against occupational injury and disease and pension contributions (but not health insurance). Income must not exceed three average monthly wages in the previous six months. While seemingly a low

barrier, take-up is low, possibly because much of the undeclared work is carried out by undocumented migrants and because the probability of labour inspections in households is considered to be low. In Germany, since 2015, an equivalent to the ‘mini-job’ system has been used in domestic and care work. Service users must buy one voucher a month, which is a symbolic payment for protection against occupational injury and disease and towards the pension security of workers.

Across the EU, tackling undeclared work is focused on reducing the cost of compliance with the legislation (for example, with low taxes and straightforward administrative procedures/reduced regulatory demands). This is often done in combination with stronger controls (including the use of confidential phone lines) and penalties for non-compliance, without specifying LTC (for example, measures implemented since 2015 in Bulgaria; also in Croatia and Latvia) and, in countries where undeclared work seems particularly uncommon in LTC, focusing more on other sectors (for example, Norway).

Reducing the cost of compliance has sometimes specifically involved home care. One example is the business certificate introduced for babysitters and carers for people with disabilities and other people with special needs in Lithuania. The fee for the business certificate depends on the period of validity, with a business certificate that is valid for one month costing €52.93. Some municipalities apply reduced fees to stimulate compliance (in Vilnius, since 2016, business certificates for carers have cost only €1 per year). However, most of this home-based LTC work remains undeclared, with around 3,600 business certificates issued in 2016 (Lrytas, 2016). Reasons for not obtaining a business certificate include the associated obligation to make social (including health) insurance contributions (Respublika, 2019) and worry that the cost will increase over time.

Undeclared work is often concentrated among migrant domestic LTC workers. When undocumented migrants are involved (relatively frequently in Greece, Italy and Spain), the work that they carry out is always undeclared. Undeclared work appears to be avoided in part by the relatively straightforward option of migrants obtaining residence permits for care work (Cyprus, Malta). Policies to regularise undocumented migrants have contributed to changing some of the undeclared work into more regularised forms of work, in particular if regularisation is explicitly connected to the employment situation. In Italy, the entitlement to government support during the COVID-19 crisis includes migrant workers providing personal care and assistance (Law Decree No. 34 of 19 May 2020). An application for regularisation could be submitted between 1 June and 15 July 2020 and covers undeclared workers of any nationality. In the case of foreign workers who were in Italy before 8 March 2020, there were two types of procedure: the first was the regularisation of existing employment relations and the provision of a work permit for irregular foreign workers (this procedure could also be used for new employment contracts), for which the employer submitted the application and paid €500; the second type of procedure involved submitting a request for a temporary work permit, if the foreign worker’s work

permit had expired after 31 October 2019 and he or she had worked in any of the sectors covered prior to 31 October 2019. The cost of this second procedure was €130.

## Sanctions and controls

Undeclared work in LTC is also subject to fines and controls. For instance, in Greece, a 2018 law introduced a fine of €10,500 for every employee found to be undeclared on personnel lists during inspections. However, in contrast to other sectors, a specific challenge for undeclared LTC work is that it usually takes place in the care user’s home. In terms of control, this is most problematic if the care is arranged between individual carers and households rather than being provided by organisations. It can be illegal without a judicial search warrant (Germany, Lithuania), and in any case difficult to enter a private household to conduct an inspection and to prove that carers are being paid. Private households may also be explicitly excluded from control by the labour inspectorate (Bulgaria, Portugal). Furthermore, as LTC-using households first need to be identified and usually only one worker is involved in each household inspected, control is labour-intensive. In practice, it is rare for labour inspectorates to check private households. However, when it concerns LTC benefits, controls may be conducted by managing organisations. For instance, in Luxembourg the Caisse Nationale de Santé carries out a home check before the allocation of LTC subsidies and, subsequently, a yearly check is carried out. In Cyprus, social welfare services conduct inspections of LTC providers.

Regulation can facilitate the work of inspectorates. For instance, it is not always possible for inspectors to determine from an employer/worker when the worker started working for the employer. An employee may have just started, explaining the lack of employment records. In Denmark, this was addressed by requiring organisations and individual households employing carers to establish appropriate records of employment before any work starts. Sometimes, only the workers carrying out the undeclared work are liable for not declaring it; however, regulation may be more effective if employers are also held responsible. In Denmark, since 2019, cash buyers of services are co-responsible even for declaring smaller payments made to LTC workers. Other measures that have been introduced are requiring wages to be paid by bank transfer and excluding employers with undeclared workers from future public procurement (Malta).

## Policies for live-in carers

In the case of live-in care, where carers often have to be available several days a week, on a 24-hour basis, there are often tensions with laws on working times and challenges around working conditions. Sometimes live-in care is in clear violation of the law, even where exceptions to such laws are discussed (for example, Norway). A lack of data risks policymakers neglecting these issues. For instance, in 2019, the German government answered a parliamentary question on live-in care, stating that it had no information on the number of live-in carers (country of origin, gender) or their working time arrangements and possible

infringements of the Working Time Act or any other unlawful behaviour in such working situations (German Bundestag, 2019).

Where live-in care has been regularised, there are differences in how this has been done and in how successful these policies have been in reducing undeclared work and in improving employment and working conditions. In Austria, since 2008, most live-in care has been formalised as employment or self-employment. Carers make social contributions and are entitled to social protection and they often work through agencies. Furthermore, as part of a quality assurance process, households employing live-in carers are subject to visits from qualified nurses to gather information on the care they receive. However, it can be questioned how far this process of formalisation has led to the empowerment of live-in carers, given that carers work under the strict control of care recipients and live in their homes. Furthermore, a self-employment model may undermine employment standards (EESC, 2016). In Italy, a collective bargaining framework was negotiated in 2013 between union and employer federations, regulating the terms and conditions of employment of domestic care. However, in practice, many families still employ live-in carers outside of this framework. The stipulated salary may be considered too high, even though it is one of the lowest minimum rates among collective agreements.

Effective regulation and professionalisation of live-in care can contribute to regularising this form of work, improving working conditions for many live-in carers and improving the quality of care delivery. The Austrian and Italian cases (as well as the situation in Cyprus and Malta if residence permit procedures for carers are considered) demonstrate ways to create regularised and professionalised live-in care working arrangements. However, financial support for families employing carers is likely to be needed to avoid irregular employment. For instance, in Austria (where undeclared live-in care has been more effectively reduced than in Italy), the state financially contributes to the employment of care workers, with subsidies provided only for qualified workers. Allowing live-in care to be paid from public subsidies can help to ensure regularisation (Malta, the Netherlands), unless it concerns cash benefits where there is a lack of control over what these benefits are used for (Germany).

However, in many high-income countries with relatively robust LTC systems, live-in care is almost non-existent, suggesting that this form of employment with large risks for working conditions can be prevented from occurring at all. Facilitation of flexible home and community-based care options and good access to supported living arrangements are important factors in this regard.

# 6 Discussion and conclusions

The EU's LTC workforce has grown by one-third over the past decade and is expected to grow further. Countries are experiencing staff shortages, and many countries expect these shortages to increase. There is still heavy reliance on informal LTC by family or friends, with about seven times more informal LTC providers than formal LTC workers. This comes at a cost in terms of loss of employment (and tax revenue) and health problems (and healthcare costs), calling for further expansion of formal LTC. The LTC workforce is key in delivering LTC and improving the quality of life and employment prospects of older people and people with disabilities, enabling them to enjoy their rights (EPSR, UN CRPD). Given the topic's (increasing) importance, it is surprising that there are many EU-level data gaps on LTC workforce-related issues. This report contributes to filling these gaps, bringing together national-level information and EU survey data to improve understanding of the LTC workforce, focusing on working conditions.

The report found that several characteristics of the LTC workforce and of the nature of employment are distinctive, compared to other sectors and even to another key care sector: healthcare. For instance, part-time work is particularly common and self-employment is uncommon. LTC has a larger and faster growing share of workers aged 50 years and over. The LTC sector is also frequently associated with poor working conditions, such as exposure to specific physical risks, including the frequent lifting of people and having to deal with infectious material, with insufficient training. LTC workers also frequently experience adverse social behaviour at work. The LTC sector consists of many low-paid professions. Policy action to improve working conditions in LTC and to improve access to high-quality LTC has a gender dimension: even more than in healthcare, most LTC workers are female; enabling users to access formal LTC frees up mainly female informal carers; and most LTC users are female.

The LTC sector has been hard hit by the COVID-19 crisis and often has not been well equipped to cope. It is hard to predict the impact of the crisis on workforce dynamics, with more people looking for jobs and more workers moving from LTC to healthcare or other sectors and fewer signing up to work in close-contact professions. The incidence of sick leave may also be higher. LTC expenditure may increase because of COVID-19 prevention measures and protocols (WHO, 2020), public and private funding limitations may further increase and countries' deficit spending may be relaxed. LTC spending may or may not be prioritised. However, it is unlikely that the trend of a rising share of employment in LTC will be reversed and that workforce shortages will disappear. Shortages of workers lead to gaps in service delivery, but also lower quality services and working condition issues as a result of LTC workers not having the time to do the job properly.

This concluding chapter summarises the key workforce issues that have emerged. General strategies to attract workers have been discussed in this report, including information campaigns, reducing barriers to workforce integration, improving education and training, and improving working conditions more broadly. Here, the findings of this report in terms of the characteristics of the work and workers, and the working conditions, are jointly discussed against the background of strategies needed to make the sector more attractive. The focus is on aspects of working conditions that appear to need specific attention, not only to attract and retain workers, but also more generally to improve conditions in the sector, in particular among the most precarious jobs in LTC. This part concludes with a plea that, given that public funding plays an important role in LTC, this public leverage be used effectively in enforcing appropriate working conditions and preventing undeclared work. This chapter then discusses among which population groups the required LTC workers may be found. Finally, it is argued that, even when they are available, both data and social agreements too often are not specific enough to LTC. Greater acknowledgement of LTC as a sector could change that. How shortages of workers are addressed and the improvements that are made to working conditions will shape the future of LTC, the people who provide it and those using the services.

## Overview of main issues

### Acknowledging and addressing LTC-specific risks

The LTC sector is characterised by various challenges around working conditions. Improving working conditions would help to reduce absenteeism, retain the workforce and attract workers. An important motivator in LTC is the widespread perception among LTC workers that the work they do is meaningful, even somewhat more so than among healthcare workers and much more so than among workers in other sectors. Interpersonal aspects of the work are arguably even more important in LTC than in healthcare, as quality of life rather than cure is more often the key objective (Rodrigues, 2017, 2020). To guarantee quality LTC and address staff shortages, it is important to value human resources in LTC and improve working conditions.

The nature of LTC work has implications for working conditions. For example,

- users are often physically frail and physical contact is required to help people get out of bed, wash and dress
- many users have forms of dementia, posing mental, emotional and physical challenges
- LTC needs continue at weekends and at night



These aspects of LTC needs help to explain some of the negative working conditions identified: atypical working hours (frequent work at night and during the evenings and, even more so than in healthcare, at weekends), shift work (with accompanying work–life balance problems), short-notice work, high levels of emotional demands and alarming rates of adverse social behaviour at work. The magnitude of these negative aspects would probably be more pronounced if the focus of analysis in this report were only on care workers, rather than the entire LTC workforce. Furthermore, the data on working conditions in this report are largely based on surveys among workers, and, similarly, the adverse working conditions identified would probably be more pronounced if those who have left the sector were also included. Job retention is a major challenge in LTC, as the findings in this report confirm; this is also the case for social services more generally (Turlan, 2020).

Some challenges around working conditions thus seem to be engrained in the nature of LTC work, which makes it hard to address them. However, they may be mitigated by better staffing and training and making the work more attractive in other ways. The way that LTC workers have in their working time arrangements could be increased, as many workers feel that they have no say, or working times could be made more predictable. It is important that real working hours match those agreed in contracts, an important factor for job satisfaction (AK Wien, 2019). Other areas for improvement of working conditions, beyond pay, are providing more training and more information on health and safety risks. While training is more common than in other sectors, perceived training needs are higher and the healthcare sector scores better on feelings of being ‘very well’ informed. The COVID-19 crisis will have increased awareness of the risks and concerns, as well as the need for more protective equipment.

Physical occupational risks in LTC often come from lifting or moving people (more often than in healthcare) and being in contact with potentially infectious material such as bodily fluids and waste (similar to healthcare). While physical risks in other sectors, for example, in factories (loud noises, extreme temperatures, vibrations), have probably reduced over time, for instance through automation, this has been less the case in LTC. Training in kinaesthetics – learning about body motions and lifting techniques – can help in both residential and home care settings. Even if many care jobs are sometimes considered to require few qualifications, particular skills are needed in LTC, and identifying and developing those skills can contribute to developing the sector and its specific areas. Technology, such as robots, can help carers to lift care users (Eurofound, 2019a). However, the application of such technology has so far been limited, although this may be stimulated by the COVID-19 crisis, with the need to reduce physical contact between carers and users. The use of technology may be easier in residential care than in home care, except in some specific cases (for example, increased self-medication and self-monitoring for LTC users with diabetes, which can also reduce LTC workers’ workload and care outcomes). Furthermore, the LTC workforce consists of a relatively large share of people aged 50 years

and over, and the physical demands of the work may be particularly challenging for these older workers, who may already be physically worn out (Pailhé, 2005). On average, COVID-19 and other viruses (influenza) also have a worse impact on older workers than on younger workers.

### Mental health risks in a growing, female-dominated sector

Traditionally, the attention paid to the health risks of work has focused on physical health risks, with less consideration for mental health risks such as depression and anxiety. With the high levels of emotional demands of the work and frequent experiences of adverse social behaviour at work, LTC is notable for its mental health challenges. To make LTC work more sustainable, it is key to address these challenges. As the sector increases in size, there is an even greater need to address these challenges. Furthermore, mental health problems already cost the taxpayer an estimated 4% of the EU’s GDP annually. This is due to direct costs to the healthcare system (1.3%) and social security system (1.2%), and indirect costs because of lower productivity and employment (1.6%) (OECD/EU, 2018).

The need to better acknowledge mental health risks also has a gender aspect. As more and more women enter the workforce and the employment gap decreases, women are taking on more occupational health risks. LTC is an important employer for women and the past decade has shown hardly any sign of it becoming more gender balanced. Furthermore, women who work in LTC are more likely than men working in LTC to deal directly with people other than their colleagues. A failure to fully acknowledge the mental health risks in LTC could therefore impact a relatively large, and increasing, number of women. This could have implications for the gender difference in (healthy) life expectancy (still more favourable for women) and the ability to work until the (increasing) pension age.

In terms of prevention, for instance, experiences with adverse behaviour at work can be addressed through increased personnel/time resources and training of staff. Appropriate supervision and discussions about adverse behaviour with colleagues and superiors can also help (Bauer et al, 2018). More comprehensive aggression management systems could also be developed, taking inspiration from mental healthcare (Cowman et al, 2017).

### Tackling the issue of low pay

The LTC sector employs many low-paid professions, such as (social) carers and assistant nurses. Overrepresentation of such professions probably explains the low average pay in LTC. However, even the best-paid LTC workers (senior specialised nurses, social workers and physiotherapists/speech therapists/activity therapists) receive little more than the average national wage, with a few exceptions (including some managers, information and communication technology professionals and legal experts). Furthermore, in some Member States, there are large groups of workers providing domestic LTC, at even lower pay, often not captured by these statistics.



Comparison with healthcare is probably most relevant for nurses, who form an important share of both the LTC workforce and the healthcare workforce. Often their basic/minimum pay is set by agreements that cover both LTC and healthcare, and differences in pay can mostly be explained by level of training and experience (which tend to be higher in healthcare). However, sometimes, pay is better in healthcare than in LTC for people with the same qualifications, while the reverse is rarely true. This makes recruitment and retention particularly challenging in LTC, in particular for skilled nurses (for whom more work is available in healthcare).

Overall, the healthcare sector seems to be a more attractive employer. However, there may be areas where LTC compares favourably with healthcare. Tasks and responsibilities differ between healthcare and LTC. For instance, while still considerable in LTC, there is less of a need for reporting and data collection in LTC than in healthcare, which may render LTC more attractive. In addition, the sense of meaningfulness of the work in LTC surpasses even that in healthcare, with carers often having close and longstanding contact with users. It is important to cherish and further improve such positive aspects of LTC work.

Policymakers seeking to attract workers, reduce inequality between men and women and address deprivation could consider improving pay in the LTC sector. This could be achieved partly through more general minimum wage policies, as many of the low-paid professions in LTC earn minimum wages or just above, which tend to be adjusted upward when national minimum wages increase. However, the low income is exacerbated by many LTC workers working part-time hours only. Facilitating increased hours for those who want them is another important policy avenue, not only to address staff shortages but also to improve the living conditions of LTC workers.

### Addressing specific challenges for home care

The general trend is to enable people with LTC needs to live longer in the community. Good access to high-quality home and community-based care services is a key element in achieving this. If provided to people with early-stage LTC needs (for IADLs), such care can also facilitate early intervention and prevention (Eurofound, 2019a). Furthermore, home care (the main form of non-residential care) can be particularly instrumental in better addressing LTC needs in rural areas (Matei et al, 2019).

It is of concern that many dimensions of working conditions tend to be worse in non-residential LTC, which mainly consists of home care. The evidence presented in this report is based on the pre-COVID-19 situation. Since then, challenges have increased further. Data from Germany indicate that over half (52%) of home care workers report that their work has become more burdensome and one-third (34%) report that conflict situations with the care receiver have been more frequent since the COVID-19 crisis emerged (Horn and Scheweppe, 2020).

One aspect of working conditions where non-residential LTC scores more favourably than residential is that work in the evenings, at night and at weekends is less common in

non-residential care. However, if more flexible models of home care were to be offered, this may change, as more users may need home care outside typical hours. This means that there is some tension between ensuring more flexible services for users and improving working hours for the workforce. Making working hours more predictable, improving other aspects of working conditions and improving staffing could contribute to ensuring both flexible high-quality care for LTC users and a more sustainable working environment for LTC workers.

Average pay in non-residential LTC has caught up with that in residential care and is now almost on a par with pay in residential LTC. However, detailed data presented in this report have shown that pay for similar professions tends to be lower in non-residential LTC. Furthermore, large particularly low-paid sections of home care are often excluded from the statistics, such as carers employed by smaller companies or households.

Overall, job insecurity in home care is larger than in residential care. Permanent contracts are relatively common in the LTC sector, but these are clearly concentrated in residential LTC and are rarer in non-residential LTC. Besides temporary contracts, zero-hour contracts, self-employment, undeclared work and platform work are also less common in LTC than in other sectors, but more common in home care than in residential LTC. There may be multiple explanations for this. For instance, home care has expanded more recently, with a trend of deinstitutionalisation in various Member States and an emphasis on helping people who want to stay at home. In this more recent era, marketisation and flexible contracts are more common and there has been a greater focus on efficiency (reducing costs), for instance, by contracting out to the lowest-priced services. Some initiatives have been introduced that change the delivery model of LTC, with better working conditions. For instance, in Ireland a home care cooperative was established to deal with problems in the private sector: issues with pay, transport (ensuring employment in a carer's local area) and uncertainty over hours (*TheJournal.ie*, 2020). In the UK, plans for a time bank system have emerged, where volunteer LTC providers bank hours of credit to be redeemed in kind for their own future LTC needs (*The Economist*, 2016).

Insecure work arrangements make home care workers particularly vulnerable to economic crises. When government spending was cut during the 2007–2008 global financial crisis and subsequent recession, home carers with temporary or zero-hour contracts were often the first to lose their jobs or work (Eurofound, 2014). During the COVID-19 crisis they have been more vulnerable to the impact of reduction in demand for their work because of government restrictions and the hesitance of users and family members to have carers enter users' homes. In addition, government support measures have been less likely to reach these carers than residential carers with permanent contracts, or to compensate them enough. At the same time, the concentration of zero-hour contracts, self-employment and undeclared work in the home care setting provides a strong financial incentive for home care workers to continue working while ill (presenteeism).

Besides being a problem for the health and wellbeing of workers, this also risks spreading illnesses to LTC users.

There is a key distinguishing feature of home care that provides additional challenges with regard to working conditions: the work takes place in the homes of LTC users. This is of great importance in facilitating people to live longer in the community and improving the quality of life of users. However, it also comes with challenges for workers. The working environment may not always be well adapted and secure, peer support from colleagues is lacking (while the worker is with the care receiver and possibly their relatives), and travel to various locations is often needed. Better development of community-based care, where care is provided at centres in neighbourhoods rather than in the home, can play a role in complementing home care and addressing some of the home care-specific working condition issues. More cooperation with other social services can also help to support home care workers better.

Verbal abuse, physical violence and sexual harassment is more common in residential LTC than in non-residential LTC. This may be explained by residential LTC being focused on people with higher degrees of LTC needs, including those with more advanced forms of dementia and those in higher need of support with physical care. Abuse that occurs in a home care setting may often go undetected; it is hard for employers and colleagues to support the carer and to intervene at an early stage. As the general trend is to enable people to remain at home, and people with higher degrees of LTC needs are likely to require care in the home setting, challenges for home carers may increase as well. Training is needed to support professionals in adapting to this shift in settings and service models and could also include training for care users.

In general, employers are responsible for carrying out risk assessments to ensure the health and safety of workers in the workplace. It is more challenging for employers to ensure the health and safety of workers in each home being visited. For instance, ergonomic supports that would be available in a residential setting are less likely to be available in the home care setting, posing greater risks of physical injury. Higher self-employment in home care further complicates health and safety issues as there is no employer to ensure that protocols are followed.

Travel by home carers between the homes of home care users is often unpaid. Social agreements (the Netherlands) and regulation (the UK) can address this, but are rare and not always enforced. Travel implies additional risks, in particular related to road safety (EU-OSHA, 2008, 2014). Non-payment of travel is also of concern in the emerging platform models of home care delivery (and for home care workers with zero-hour contracts), as are other challenges such as the level of pay, training and quality assurances.

There are also positive aspects that are specific to home care, such as greater autonomy (Bauer et al, 2018). If well facilitated, home care workers can work close to home, enabling them to also undertake informal child and elderly care responsibilities (which many LTC workers have) and reducing commuting time. Such advantages should be valued. They can be reinforced by care models that focus

on ensuring that decisions are taken as close as possible to service users and by placing more trust and responsibility in those closest to them: front-line care and support workers. Reducing administrative burdens by separating care and administration and using technologies can help. Examples of such models include those used by Buurtzorg in the Netherlands and Enable Scotland (EASPD, 2019).

### Improving the situation of domestic and live-in carers

In several countries, domestic LTC workers provide a large share of LTC but they are often excluded from LTC statistics and reports. Undeclared work in LTC is also concentrated in domestic LTC, while rare in other areas of LTC. The COVID-19 crisis has resulted in a reduction in working hours (or job losses) for domestic workers in northern, southern and western Europe, which peaked in mid-April 2020 at an estimated 50% (ILO, 2020). They have usually fallen outside policy measures to support people affected by the crisis, even if some Member States have sought to include them (for example, Italy). Domestic LTC workers also risk falling outside policy measures relating to health and safety regulations. Domestic work is excluded from the scope of the Framework Directive on Occupational Safety and Health, and it is left to Member States whether or not to apply the EU's 2019 Directive on Transparent and Predictable Working Conditions to this group. The European Parliament (2016) has urged EU Member States to ratify the 2011 International Labour Organization's Convention on Domestic Workers. By September 2020, six Member States had done so: Belgium, Finland, Germany, Ireland, Italy and Sweden. These countries committed, for instance, to take measures to ensure that domestic workers enjoy:

- equal treatment as workers generally in relation to normal hours of work, compensation for overtime, periods of daily and weekly rest and paid annual leave
- minimum wage coverage, where such coverage exists, and remuneration without discrimination based on sex
- effective protection against all forms of abuse, harassment and violence
- a safe and healthy working environment

Where regulation exists, enforcement is a challenge in domestic LTC, in particular because employers and workplaces are private households, not organisations or companies. Labour inspectorates do not generally check individual households. Often, they are not allowed to enter private houses without a warrant and, when they are allowed, such visits are resource intensive.

In national statistics, when data are available, domestic LTC workers are often captured together with other domestic workers (most notably cleaners and childminders). This complicates an understanding of their role in LTC and their working conditions. Even though domestic carers' tasks often include cleaning, it would be useful to distinguish between those who do not perform care tasks and those who do, and ideally the type of care they provide (childcare versus LTC).

A specific form of domestic LTC work with particular challenges for working conditions is live-in care, where the carer lives with the LTC user. This form of care is incompatible with regulations such as the Working Time Directive, but can play an important role for users (EASPD, 2017). Live-in care is usually provided by mobile citizens or non-EU migrants. In low-income Member States where populations are ageing, more and more people can afford live-in care (often provided by non-EU migrants) and, if there is limited access to good-quality alternative LTC services, live-in care is likely to increase. There are also signs of increases in live-in care in some higher-income countries. The COVID-19 crisis has likely diminished trust in larger-scale residential LTC, which often has not managed to keep the virus out, resulting in high death rates. This could accelerate the shift towards home and smaller-scale community-based care. Demand for domestic care, and in particular live-in care, may also increase, to reduce the risk of spreading the virus through carers visiting multiple users. Changing carers is also often considered to be a negative aspect of LTC quality, in particular for people with dementia (SCP, 2018). There is a risk, though, of spreading influenza/COVID-19 through ‘presenteeism’, especially for domestic carers who do not live with the care user. Even more so than for home carers not directly employed by the household (see above), domestic carers lack sick leave entitlements, providing strong financial incentives to continue working while ill.

Regularisation of undeclared domestic LTC can be achieved by making regularisation easier and more attractive for the worker and employer. Austria has largely regularised live-in care by setting a low barrier for regularisation. However, as a consequence, minimum working condition standards are low. Italy is exceptional in having a collective agreement for domestic LTC workers, including live-in carers, and does better on minimum standards. However, the downside is that undeclared work is still prominent, partly because stipulated wages (and thus costs for households) are considered high. Germany and Spain, where undeclared live-in care is common, can learn from these experiences. Some countries (Cyprus, Malta) have relatively well-established routes for migration, with regulated conditions for live-in care, preventing irregular employment. With employment agencies playing an important role in the international placement of live-in carers, there have also been calls for a Europe-wide register of these agencies, with agencies needing to demonstrate compliance with certain standards to be included in the register (AK Europa, 2020). Training can also help to improve the quality of care and working conditions (for example, by teaching lifting techniques), with initiatives recorded in Austria (‘Train to Care’ by Caritas) and Italy (2015–2017 Erasmus+ project ‘Sole24ore’, or ‘Formazione per l’assistenza domiciliare 24/24 ore’), for example. Training can also target carer-employing households, helping them to become good employers.

Overall, all countries where live-in care currently plays a large role could learn from countries where live-in care is uncommon because of good access to flexible alternative modes of home care.

## Addressing precariousness by using public leverage

In contrast to sectors where public funding tends to be uncommon, governments have tools to enforce working condition standards in LTC, in the public and private sectors.

Where the public sector subcontracts LTC provision to private providers, it can request conditions in tender documents. For instance, to address precarious work arrangements, Malta has included conditions in its tenders for private providers (and subcontractors) of government services (including LTC): the obligation to specify minimum hourly worker costs, a ban on using bogus self-employed workers, providing workers with detailed payslips, paying wages via direct payments to employees’ bank accounts, excluding companies from tendering for five years if found guilty of precarious employment and mandating hourly rates that private contractors have to apply (Eurofound, 2015b; DIER, 2017).

Where people are entitled to publicly funded home care services, but choice is left to the user (for example, through a voucher system, monetary benefits or reimbursement), governments can set conditions. For instance, choice can be limited to providers that have demonstrated that they fulfil certain minimum conditions, or payments can be discontinued if a household cannot demonstrate that certain conditions have been adhered to (for example, minimum payment of domestic LTC workers). Conditions can also be set regarding training, benefiting LTC professionalism. For instance, in Austria, a live-in carer needs to have completed – as a minimum – a home help course in order for the user to be entitled to a subsidy. In the elderly care procured and provided publicly in Denmark (122,000 people above the age of 65 receive practical assistance and personal care in private homes), personal carers are required to have at least a 2.5-year degree in social and health care assistance (Mailand and Larsen, 2020). The extent of this leverage depends partly on the availability of funding but, even in funded LTC, leverage is sometimes not used (for example, the case of cash benefits without accountability for what they are used for).

## Sourcing the required LTC workers

To address shortages, policymakers should target specific population groups. The following groups seem to have particular potential, in terms of both motivation and the possibility of integrating them in the short term because of their expertise in LTC. However, there are also challenges attached and much of the targeted recruitment will fail if more sustainable working conditions are not created simultaneously. This is also key to reducing staff turnover and absenteeism, and thus responding to staff needs and improving service quality.

**Part-time care workers:** More effort could go into exploring how part-time workers could work more hours, in particular as many want to work more hours. In some countries, there seems to be scope to increase hours among part-time LTC workers who want to do so (Denmark, France and Sweden). In Sweden, home care

workers, especially, want to increase their hours, whereas in Germany it is mainly residential LTC workers who want to increase their hours (Bauer et al, 2018). More part-time workers might want to increase their working hours if working arrangements (working hours, predictability) allowed them to combine their work with informal childcare and elderly care commitments, or if they could adapt work better to their own disabilities or illness. It will be important to balance increased working hours with measures to ensure that the work and workers are not affected by the additional physical and mental health strains.

**Care workers who have retired or who will soon**

**retire:** Given the large share of workers aged 50 years and over, there is scope for facilitation of work beyond the retirement age for those who want to and can do so (Eurofound, 2012). As the physical and mental health burden of LTC can be even more of a strain for older workers, it is key that such targeting comes with improved working conditions. The long-term potential lies in improving working conditions over the life course (from an early age onwards) so that more workers can continue working beyond retirement. Specific age management measures can also help, including flexible working schemes to facilitate informal care, which LTC workers often provide, and a reduction in working hours combined with a partial pension (Eurofound, 2016; Merkel et al, 2020).

**Inactive or unemployed informal carers whose caring commitments have reduced or ceased:**

Informal carers often have problems reintegrating into the labour market once their caring commitments cease or reduce, contributing to long-term costs to society (Eurofound, 2019a). Poland has a programme to recruit 'ex-carers' by accrediting acquired skills (Social Protection Committee and European Commission, 2014). However, ex-carers may envisage other career paths and informal LTC skills may differ from the skills needed for formal LTC.

**Unemployed and economically inactive people or workers who face redundancy:**

Inter-occupational career pathways and upskilling those workers who may already have relevant skills could be facilitated among unemployed and inactive people, and among workers who face redundancy (see example under 'Initiatives to reduce barriers').

**New students:** While LTC staff shortages are apparent and expected, Member States rarely make projections that take into account developments in the enrolment of students and trainees. Measures to attract students and trainees could form part of a longer-term solution. They include campaigns in schools, but also general societal campaigns to address negative stereotypes of old age, disability and LTC work (see section on 'Policies to make the sector more attractive').

**Migrant and mobile workers:** Foreign workers already play a larger role in LTC than in healthcare, and more so than official statistics suggest if undeclared domestic carers are fully accounted for. For policymakers wishing to further expand the LTC workforce by attracting foreign workers, language training and skills training are

important policy areas. Language courses and tailored support for soft skills can open up certain LTC jobs that require a high level of communication with users or interactions with other services. However, language training does not always provide the skill level required to communicate sufficiently well in person-centred LTC. Certain training requirements can also be a barrier, which can be overcome by specific agreements or the facilitation of training (see section on 'Policies to make the sector more attractive'). However, even with improved upskilling support, policymakers face additional challenges in preventing staff shortages. In many western Member States with larger LTC sectors, mobile workers from lower wage Member States are an important part of the workforce, especially in certain subsectors. However, with this carer contingent ageing, and wages increasing in their home countries, their presence may decrease.

**Men:** Overall, men probably have the largest longer-term potential to reduce staff shortages in LTC. Over four in five LTC sector workers are female (with an even higher rate if only LTC sector workers who provide direct care, and not support workers, are considered). Addressing stereotypes could help to attract more men, opening up a large pool of potential LTC workers. Increased efforts should be made to attract and retain men among the other groups discussed here to prevent the reinforcement of gender stereotypes, as women are overrepresented in most of these groups.

### Recognising LTC as a sector

Information on LTC at EU level is more limited than, for instance, that on healthcare. With the LTC sector expanding, this is becoming increasingly problematic. Lack of visibility may partly explain why LTC was often not well enough equipped to deal with the COVID-19 pandemic. One specific challenge is that LTC is often combined with other types of care (other social services or healthcare) and data do not allow for disaggregation. Furthermore, large sections of LTC are often excluded from reporting (such as domestic LTC or home and community-based care). This report has gathered available data at the Member State level, showing variations in terms of both the level and the type of information.

Only rarely do collective agreements specifically cover (large sections of) the LTC sector. When the LTC sector is covered, this is often jointly with healthcare and other types of care. At the social services level (NACE codes 87 and 88, therefore including childcare), social dialogue takes place at EU level and national level (Turlan, 2019). In many Member States, large sections of the LTC workforce are left uncovered. It has been argued that there is a vicious circle with unfavourable working conditions leading to large turnover rates among care workers, leading in turn to lower worker representation and a lack of pressure to improve working conditions (Milos and Bergfeld, forthcoming).

However, the situation is varied in LTC. Social dialogue has the best coverage in the public LTC sector and is better in residential LTC than in non-residential LTC. Only a few countries have agreements that cover LTC domestic workers/personal assistants employed by households (Finland, Italy). In practice, however, even in these



countries domestic LTC workers in particularly vulnerable situations remain uncovered by such agreements. This order of coverage by collective agreements seems to go hand in hand with working conditions tending to generally be better in residential LTC than in home care, and worst in domestic care (in particular if undeclared – and thus surely not covered by collective agreements).

The LTC sector is expanding in size. Furthermore, the European Commission has encouraged Member States with few formal LTC services to strengthen these services. It may therefore be time for LTC to receive more recognition as a sector and for data collection specific to LTC to be improved. LTC-specific education and training are also important for the professional integrity and recognition of care work (Schulmann and Leichsenring, 2014). Getting the qualifications and skills right to match the jobs well is an important area in shaping the workforce in LTC in the future.

As part of increased recognition of LTC as a sector, collective agreements could more explicitly single out the sector. This is already done in some countries (Luxembourg and the Netherlands). These two countries, which have large LTC sectors, happen to be among those with the most favourable average wages for social services. There are risks involved with LTC-specific collective bargaining. For instance, worse working conditions may be negotiated than if LTC is joined up with healthcare, and integrated care delivery should not be jeopardised. However, better recognition of the LTC sector could contribute to addressing the many specific challenges in the sector, such as those outlined in this report.

## Policy pointers

- Interpersonal aspects of work are key in LTC. To guarantee high-quality LTC and address staff shortages, it is important to value human resources and improve working conditions in the sector.
- To address staff shortages, measures could target part-time workers who want to increase their hours, unemployed and inactive former informal carers, LTC workers who want to delay their retirement and young students-to-be. Men in particular could be targeted. However, for these measures to be effective, more sustainable working conditions are needed.
- As the LTC sector grows, it is increasingly important to acknowledge the specific physical risks that LTC workers face, including those relating to lifting people. The COVID-19 crisis has shown that LTC workers must be better prepared to work safely in potentially infectious environments. The physical demands of LTC and the risk of infection from illnesses such as influenza/COVID-19 tend to affect older workers, who are overrepresented in LTC, more severely.
- LTC workers have a high risk of developing mental health problems because of the high levels of emotional demands of the job and exposure to adverse social behaviour at work. With the growing LTC workforce, it is particularly important that this is addressed by policymakers. Mental health problems are associated with high costs to society. Ignoring them affects women disproportionately as more women than men are employed in the LTC sector.
- Better staffing levels can reduce the need for short-notice work and, together with increased professionalisation, training and improved processes, can reduce the physical and mental health challenges of LTC. More time with service users, fewer administrative tasks, greater autonomy and increased professionalism can also contribute to better services.
- Home and community-based care services are key in enabling people with LTC needs to stay in the community. The COVID-19 crisis may accelerate the move away from large-scale residential LTC. However, the care user's home as work environment is hard to regulate and control. Training (for example, in kinaesthetics), aggression management, technology and better staffing can help to improve working conditions.
- Domestic LTC work in particular needs to be better covered by regulations and collective agreements, which should be enforced, with attention given to the specific risks of care work and ensuring that travel between care users is remunerated appropriately.
- Live-in care, where the LTC worker lives in the care receiver's home, is associated with risks around working conditions and quality of care. Regularisation can be facilitated by attractive registration procedures. However, if good access to a flexible range of high-quality LTC services is offered, live-in care is rarely needed.
- In contrast to many other sectors, public funding plays a role in LTC. Governments can use this to improve working conditions, for instance through requirements in public procurement. Undeclared LTC work can be addressed by improving access to flexible, high-quality LTC, with public support restricted to registered providers and declared care.
- Acknowledging LTC as a distinctive sector in data collection and collective agreements or regulations, and improved coverage of collective bargaining, can help in improving evidence for policies, creating a better working environment and enhancing service quality.





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# Annex: Network of Eurofound Correspondents

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**Long-term care workforce: Employment and working conditions**

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The long-term care (LTC) sector employs a growing share of workers in the EU and is experiencing increasing staff shortages. The LTC workforce is mainly female and a relatively large and increasing proportion is aged 50 years or older. Migrants are often concentrated in certain LTC jobs. This report maps the LTC workforce's working conditions and the nature of employment and role of collective bargaining in the sector. It also discusses policies to make the sector more attractive, combat undeclared work and improve the situation of a particularly vulnerable group of LTC workers: live-in carers. The report ends with a discussion and policy pointers on addressing expected staff shortages and the challenges around working conditions.

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**The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.**

