User Commissioners Report

Erasmus+

This project has been funded with support from the European Commission. This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.
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Foreword

Helpcare Project aims to develop and transfer innovative practices in education for the qualification and professionalization of health and social care workers that can be adapted and adopted across Europe to make better use of the existing workforce through training.

The project also encourages young people to view health and social care work as a career choice with recognized routes for progression.

The Users Commission Report is a compilation of the views of the partners of the project in relation to the issues related to existing regulations in partners’ countries, qualifications, impact on immigrant workers on users of health and social care. The perspective of care users is taken into account, as well as that of care commissioners in each partners’ country.

The report reflects the information obtained through desktop research, interaction with social and health commissioners and users of care services. Partners reports reflects different realities in partners’ countries but also the different perspective of partners’ organizations – NGO, universities, local authorities.

The Users Commissioner Report aims to increase our understandings of commonalities or discrepancies among EU partner countries in regards to the role of regulation, qualifications for health care provision, issues of cost, impacts of immigrant workers, on users of health and social care.
United Kingdom

Introduction and Overview
The aim of this report is to highlight the research findings of the Helpcare Project (UK) to date. These findings emerged from data collected from a variety of sources; interviews with carers, prospective users of services, service providers and a review of relevant and current literature. Issues relating to commissioning, regulation, qualifications, cost and the impact of immigrant workers are also included.

It is important to begin with an overview of some of the factors which are influencing the delivery of home care for the elderly; service provision and commissioning. There is no doubt that the need for health and social care services for older people is set to rise. The UK population’s changing demographics predict an increase in the ageing population and its impact on social care will ultimately require a significantly higher number of employees in the adult social care sector in the future. By 2041, the number of people in England aged 85 is expected to increase by 2.5 times the 2010 figure to 3.2 million representing 5% of the total population (Skills for Care, 2015). There are near to seven million carers in the UK which equates to one in ten people. (www.carersuk.org, 2015).

Home care for older people is commissioned in a number of ways. Commissioners include; social services, health authorities, families and the older people themselves. Despite some of their differences, all of these ‘commissioners’ really have the same objectives or desired outcomes from a home care service; person centred, well led, value for money and user involvement for example.

However, it is fair to say that budget cuts are putting commissioners under increasing strain to buy in affordable services. There are a number of reports which give guidelines and advice to those responsible for commissioning services. For example the Local Government Information Unit (LGiU) carried out a survey to determine the extent to which ‘outcome based’ commissioning is used. Furthermore, the Social Care Institute for Excellence (SCIE) also state that an emphasis on outcomes would be more beneficial than merely concentrating on hours used “approaches that are focused on what can be achieved rather than on the number of hours of care received or the type of care received” (www.scie.org.uk, 2014).

Care is currently provided by informal and formal carers (unpaid and paid) Skills for Care (2015), estimates that the number of paid adult social care jobs could increase from the current 1.63 million, to between 2.1 million and 3.1 million by 2025 and over the next 30 years, the number of carers will probably increase by 3.4 million (around 60%). To cope with this predicted growth of adults requiring supported care, it will be necessary therefore to significantly increase the number of trained and qualified employees in the adult social care sector, or risk having inadequate care provision in the future.

Most people who need care rely on family members, friends and neighbours these are categorised as informal carers. National surveys estimate that there are approximately 6.4 million family carers in the UK, an increase of over 10% since 2001. This figure represents 12.6% of the adult population. It is predicted that this number of informal carers will soar to nine million by 2037 and that three in five adults in the UK will become a carer at some point in their lives. (www.communitycare.co.uk, 2012). With the increasing number of people taking on informal care roles, clearly there will be a need to provide greater help, information and guidance to support this growing area.
Qualifications and Training

In the future, informal carers may need to access some of the existing training offered to the formal workforce to provide effective care. Justine Cawley, director of the Elizabeth Care project supports this view in an article (www.telegraph.co.uk, 2015); she states that “To deal with our ageing population – and one with increasingly complex conditions, we not only have to train the existing workforce......that should include training unpaid carers”

In a report by Skills for Care (2011), the social care workforce (excluding managers and social workers) is relatively unskilled. In 2010 two-thirds (67 per cent) of people working as ‘care assistants and home carers’ claimed to be qualified to the basic NVQ Level 2 or above, and 7 percent had no qualifications at all.

The previously recommended Common Induction Standards (CIS) has now been replaced since the 1st of April 2015 by the Care Certificate. The Care Quality Commission (CQC) who are responsible for the inspection of care providers expects providers to induct, support and train their staff appropriately. Their expectation is that those who employ health care support workers and adult social care workers should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction (CQC, 2015).

However, this qualification is not mandatory which could still create inconsistency in the quality of service provision. Having said that Skills for Care maintain that employers still have to ensure the CQC at inspection they are compliant with the provision of training and induction and this could be met in part by the Care Certificate. A report on a pilot of the Care Certificate states that although there will be formal assessments required that the common view was that poor quality training will not necessarily be improved by its introduction. In its defence the report claims that the Care Certificate was not brought in to specifically address training and goes on to say:

“So whilst some pilot leads would question whether enough priority is being given to eradicating poor quality training across the country, they also acknowledge that the Care Certificate is well placed to introduce greater consistency in how Support Workers are prepared for their roles.”

(UNISON)

So whilst it seems that there are training opportunities available these are not always taken. A UNISON study published in April 2015 states that the safety of elderly and disabled people who rely on homecare is being put at risk because staff are receiving inadequate training, for example;

“Almost a quarter of staff (24 per cent) administering medication had received no training, despite some of them distributing drugs such as liquid morphine and insulin”

These views were clearly echoed by some of the carers interviewed and were an obvious concern;

“On that Saturday my last shift I got given medication it was a nebuliser I didn’t have a clue how to use it and I said so.... I had asked for help when I went down to see the senior carer and I said am I supposed to be trained in this and she said technically yes technically” (ULANC 6)

“So you know I can tell you I see it’s a big problem in Great Britain the care of the elderly. If you want to take care of any people you should have the good skills and knowledge. Not everybody has proper training, not everybody has good skills of working with people who have special needs you know like elderly or disabled people” (ULANC 8)

“Additionally if the carers working like a qualified carer they should every year provide some training. But not online because you are getting some knowledge you know but it is only information, you can’t taught the skills in practice they should be practise things” (ULANC 8)
During an interview with a Social Care Support Officer it was noted that the shift from local council operated home care services to private agencies could be partly responsible for the lack of consistency in training, qualifications and experience. It was felt that previous systems had a far more rigorous training programme and that standards were more closely monitored. The officer interviewed had some responsibilities for ensuring both short term and long term packages of care for older people and said that a common complaint from older people was time allocated and having to retell their situation to a number of carers as there was little continuity of care. The officer was often responsible for discharging older people from hospital and found that frequently they were not medically fit. Although the officer recognised that there was a shortage of beds, it was felt to be false economy as many of these older people returned to hospital quite quickly.

**Continuing Professional Development**

In addition to the lack of basic and essential training it seems that many carers felt that there were little or no opportunities for professional development;

“The carers don’t see any way for professional development sometimes. I meet carers for 15 years who have good skills and knowledge who were never pushed up. Do you understand? Still a simple care assistant” (ULANC 8)

ULANC 7 was noted to have said that she didn't see her career progressing but that was in part her choice although she said that unless she wanted to go into management there was little scope and many of the younger ones went into nursing. The Cavendish Review (2013) also comments of a lack of progression opportunities within social care. Whilst it recognises that some carers are happy in their current role there should be scope for those who seek advancement. However, these opportunities should not take them away from their caring role:

“In social care particularly, it will be important that talented carers do not have to move away from the frontline to get promotion” (The Cavendish Review, 2013)

67% of the services users interviewed stated that they would prefer a professional carer and not a family member, the main reason given that they would not want to be a burden on their family.

**Valuing the Carer**

Those interviewed also felt on the whole that carers were undervalued. The following information supports the view that carers are undervalued in terms of the uncertainty of their working hours; of the people currently employed in social care, 307,000 workers in England are employed on zero hours contracts (Norman Lamb, Care Minister, 2014). Zero hours contracts occur when ‘people agree to be available for work as and when required, but have no guaranteed hours or times of work’ (ACAS, 2012). According to the Office for National Statistics’ Labour Force Survey (2012), the social care sector is well above average compared to other sectors in using zero hours contracts for formal care.

Another example of how care work is undervalued is by the practice of not paying carers for their travel time. This often results in pay below the minimum wage when this time is taken into account. A subject which UNISON has commented on:

“Unfortunately – despite some councils changing their ways, like the good people at Cumbria council who signed our ethical care charter last week – this mistreatment and underpayment of...”
care workers is still widespread. And it shows just how little some local authorities value care staff doing such a vital job” (UNISON)
The older people interviewed by the co-researchers also shared the view that carers were not always valued:
“Not nearly enough….. Well they seem to have desperately poor pay and not enough time to do the job….they should be paid a decent wage to do a decent job” (ULANCa)
LMCa and LMCC also commented that they felt that carers “were underpaid for the job they do” and “not valued enough”.

Preferred Models of Care
100% of the service users interviewed by the Helpcare researchers said that they would like to be cared for at home and all but one believed that it would be better if they were qualified to do the job. All stated the importance of having confidence that the carer knew what they are doing.

“Home is a powerful symbol of autonomy and independence, whereas institutions are associated symbolically with the loss of autonomy” Ryan, A.A., McCann, S. and McKenna H. (2009)
“I would like if it has to come down to it, if I have to have care I would like to stay in my own home and have carers come to me.” (ULANC c)
“At home if that’s possible….well because it is familiar, I’ve got all my own things around me” (ULANC a)
“At home….because I know where I am and it would be comfortable and nothing else really” (ULANC b)

The Importance of Time
Time allocated for care visits was noted by some of the service users, both in terms of their own needs and the feeling that this also put pressure on the carer (another way that they were devalued)
This was backed up by views from some of the carers interviewed;
“If everyone could just have an extra 15 minutes… You know you’d be sorted but they are so tight on how long you are allocated to each person you know they are only allowed so many hours in a week” (ULANC 7)
“So really you know to spend a bit of time with somebody that doesn’t see many people during the day must be nice just to have 5 mins chat” (ULANC c)
“well as long as it takes for them to do what they have to do and a little chat you know maybe another 10 minutes quarter of an hour” (ULANC c)
A recent Unison report – entitled Suffering Alone at Home – which was based on an online survey of 1,100 homecare workers (and with data obtained from a Freedom of Information request (FoI) to the 152 local authorities in England that commission social care visits) discovered that the UNISON survey findings mirrored those of the FoI request to local councils, for example:
“Three quarters (74 per cent) of homecare workers who responded felt they did not have enough time to provide dignified care for the elderly and disabled people they visited. Worryingly says UNISON, 61 per cent said visits of just a quarter of an hour meant they frequently had to rush the care of people who were over 90 years old”(UNISON, 2016)
Discussions with local service providers reinforced this view and commented on this being more of an issue in rural areas:
“Less time is allocated to spend with clients. For example 10 years ago an hour would be allowed so that a meal could be cooked for the person. Now the expectation is on a ready meal. 15 minute visits are allocated to give medication or check on a person – totally unreasonable and unrealistic in the rural area within which we operate”
A number of carers and service providers who took part in the Helpcare research noted that there was a social aspect to the job and that they felt that they were unable to fulfil this need due to lack of time.

“Homecare workers also said that more than a third (37 per cent) of the people they saw have hardly ever had visits from friends or relatives, which is why they felt it was important to be able to spend time in each person’s home” (UNISON, 2016)

“Most people being cared for at home want a warm relationship with their paid carers and place a lot of value on conversation. A friendly and sociable carer is regarded by service users to be a marker for whether they are a good paid carer or a poor one. Paid carers themselves complain that they often don’t have time to talk to their clients, and that this part of their role is not recognised as important. Many users feel that their paid carers are constrained by time during their visits – they can either talk or do, but not both.” (Commissioning home care for older people, SCIE)

Issues of Cost and Pay

At least 70% of all homecare is purchased by the state, mostly by local councils, and by health and social care trusts in Northern Ireland. (UKHCA, 2015)

The United Kingdom Homecare Association (UKHCA) 2015 have produced a report which claims to reveal the underlying cause of the unacceptably low pay and conditions experienced by home care workers and claims that central Government’s reluctance to address this and hold local commissioners to account makes them responsible. The following figures illustrate the average price paid for an hour of homecare in September 2014;

- United Kingdom: £13.66 / hour
- England: £13.77 / hour
- Wales: £14.28 / hour
- Scotland: £13.68 / hour
- Northern Ireland: £11.35 / hour

The report claims that most councils did not pay service providers enough money to ensure that they receive the UK Living Wage (£9.40 in London, for the rest of the UK see NMW) and that this was even less likely in London. This, the report claims makes it incredibly difficult for the independent and voluntary sector to attract and retain care workers of the standard required. The report states that it is vital that local authorities pay a rate which will allow the payment of the National Minimum Wage (£7.20, £6.70 for those aged 21-24) whilst allowing enough profit for the provider to remain viable. However, paying a minimum wage to the carer is not necessarily enough as it has been seen when the cost of travel time and mileage is not taken into consideration. Furthermore, local councils or authorities who plan on the payment of the minimum wage need to factor in additional costs. For example:

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<th>Employers NI</th>
<th>LGPension Scheme</th>
<th>Total cost to employer</th>
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<td>£1080</td>
<td>£55.75</td>
<td>£198.72</td>
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Introduction
This report is not about showing exhaustive picture of the situation related to social and health care. This reports is to draft the regulations, qualifications, issues of cost, view of the practitioners and users of health and social care in Bulgaria. The information was retrieved from three different sources, namely from the available information in Bulgarian and English, interactions with commissioners of health, and the testimonies of care service users. The information retrieved included the perspective of care commissioners. Two main methods are used – desktop research and direct contact with commissioners.

Procedure and findings
Desktop research
Legal framework
The terms and conditions for establishment, provision and use of social services in Bulgaria are regulated in the Social Assistance Act and the Rules for implementation. Social services may be provided by individuals carrying out commercial activities and by legal entities established under the law of another EU Member State or another country of the European Economic Area, after entry in the Register of the Agency for Social Assistance. The mayor of the municipality manages the social services in the municipality, which is state delegated activities and local activities, and is the employer of the heads of these services.

The increasing demand of long-term care by the adult population in the context of the negative processes related to aging population highlights the need for cross-sectoral cooperation and an integrated approach in caring for the elderly and for people with disabilities. In this regard, as one of the main challenges for the long-term care system, efforts are aimed at promoting and developing the interaction between social and health services.

- Home-based social services
  Home-based social services support the social inclusion of persons/children with disabilities, elderly people living alone and other vulnerable groups. Home-based social services are: personal assistant; social assistant; home assistant; home care. These services provide care to meet the everyday needs at home. Depending on the specifics, they are aimed at: social work and counselling, assistance for the organization of leisure time and making contacts; hygiene, shopping, cooking, laundry and other public utility activities; delivery of food, assistance for obtaining the necessary aids, devices and equipment for people with disabilities and medical devices; utilities and others. The services are provided under the National Programme "Assistants for People with Disabilities" and EU-funded projects.

- Community-based Social Services
Community-based social services are central to effective social inclusion, fighting poverty and participation in society of all vulnerable groups. In recent years, policy in the sphere of social services is aimed at developing community-based and home-based services to replace the institutional care model. Community-based social services include:

- Community-based social services – day care centre (day care centre for children and/or elderly people with disabilities; day centre for elderly people with disabilities – weekly care; day centre for children with disabilities – weekly care; day care centre for old people); centre for social rehabilitation and integration; social educational and professional centre; “Mother and Baby” Unit; centre for social support; centre for work with street children; foster care; public canteens.

- Community-based social services of residential type – family-type accommodation centre for children/young people without disabilities; family-type accommodation centre for children/young people; family-type accommodation centre for elderly people with mental retardation; family-type accommodation centre for elderly people with mental disorders or dementias; family-type accommodation centre for elderly people with physical disabilities; family-type accommodation centre for elderly people with mental retardation; family-type accommodation centre for old people; temporary accommodation centre; crisis centre; transitional home; sheltered home (sheltered home for people with mental disorders; sheltered home for people with mental retardation; sheltered home for people with physical disabilities); supervised home; shelter.

Social Services in Specialised Institutions

The specialized institutions provide a set of social services for persons/children with disabilities, elderly people and children deprived of parental care. An important feature of these institutions is the fact that this is a form of care in which users are permanently separated from their domestic/family environment. Social services in the specialized institutions shall be provided after the opportunities to use community-based services are exhausted. Specialized institutions include:

- Specialised institutions for adults – homes for elderly people with mental retardation; homes for elderly people with mental disorders; homes for elderly people with physical disabilities; homes for elderly people with sensory disorders; homes for old people.

National Strategy for Long-term Care (CoM Decision No. 2 / 07.01.2014) was approved in early 2014 to develop long-term care for elderly people and improve their quality of life. The Strategy is aimed at provision of accessible, high-quality community-based and home-based services to enable the social inclusion of people with disabilities and elderly people while having preventive role in respect of the institutionalization of those persons. It places special focus on the deinstitutionalization of care for people with disabilities and elderly people, development of home-based services and support to the families, with increased responsibility for the care for dependent family members. Promoting the interaction of social and health services and the implementation of an integrated approach are also prioritized in the Strategy. One of the key priorities of the Strategy is to establish a more effective financing mechanism for long-term care and to achieve sustainable increase of funds for community-based and home-based services.
Education and Training
Several universities in Bulgaria provide education (EQF 6/7) in specialties such as:
- Social services
- Special pedagogy
- Social pedagogy
One secondary school (135 SOU “Jan Amos Komenský”) in Sofia provides education in social profession - Assistant social services (EQF 4)
Several VET centres provide trainings in professions:
- Social carer
- Health assistant
- Assistant social services
The level of qualification depends of the number of learning hours in the above mentioned VET courses. Level 4 (EQF) is for the course of the whole profession and Level 3 (EQF) for part of it.
Although there are educational and training pathways available in different qualification levels the people providing social and health care are either highly educated or without any education in social area.
The common practice in delivery of training is on-the job training organized by the employers.
Usually this training is with duration between 1 day and 1 month and the content depends only on the employers.
The professionals:
There are either staff with higher education or with secondary education, no staff with vocational training was observed.
The major part, those who have relevant qualification (psychologists, work therapists, social careres), has also the attitude to leave the profession. And these are the people who represent the part which has professional background, years invested in education and experience.
The attitude is determined by the level of payment, career opportunities, and overall organization of the work. When the staff has the attitude to leave the system whenever it is possible, it is irrelevant to have expectations for effective and efficient performance.
The social work as a functional profession is losing position as prestigious and as a source for incomes; The carers express the feeling they receive low public estimation and feel undervalued. Carers perform in an area with low public prestige, very little remuneration and lack of opportunities for professional growth. Logically, very little, even no motivation is observed.
The average incomes of the people working in the social and health services is below the average for the public sector and well below the average for the country.
The remuneration is not attractive, doesn’t keep and doesn’t motivate the staff. The managers of the organisations providing social services are trying to keep the diversification low, payment is based on position but not for contribution, and this way the professional activities and professional development are proved by non-creative attitude.
The work conditions are related to feeling of lack of results, continuous negative emotions, tension, high levels of stress which lead to emotional burnout. Parallel to the above the managers do not have vision for motivation of the staff. In most cases they do not put any efforts and do not apply any system for motivation of the staff in the organisations. Additional to this neither training opportunities, no psychological support is provided to the staff which is in direct contact with clients.

**Interaction with commissioners (co-researchers):**
The interviews conducted among formal care givers revealed a high level of professionalization in community based and specialized care centers. The majority of care givers working in institutionalized facilities has higher education mainly medical one but they highlighted the need for care givers to be evaluated frequently, in terms of having received proper and specialized training for their current post, as well as no trainings in soft skills which are badly needed in this profession. According to the informal care givers there is not enough support or training for them which leads to low quality of care providence, social exclusion, and poor balance or absence of personal life. Also the interviews conducted among care givers revealed their frustration of low payment. The payment in this professional sector is one of the lowest in Bulgaria. According to the majority of the interviewees this is obstacle in promotion of this job as a career pathway.

**Users of care services** - When it comes to informal care, the users have very well defined requirements: they expect person to be vocationally trained, to have kind personality, to be pleasant and good companion, to behave professionally but at the same time as if she (in 100% of the cases the carers were women) was part of the family. Although the informal care service as a rule is part of the grey market, the users express opinion that regulations are necessary. This comes in contradiction to the situation, where people avoid companies offering this kind of services and accept carers with no qualification as the price is lower.

**Conclusions**
Three major directions for further development should be taken into consideration:

- **Education and training** – professionals from the middle levels should acquire relevant qualification. The current situation where people are either with too high or without any education is lowering the quality at all aspects for both sides – providers and users.

- **Career pathway** – this is major aspect and is vital for attracting young people in the sector of social and health services. The lack of career pathways in front of the people involved in social and health care is mentioned as a serious demotivator.

- **Deinstitutionalisation** – since this is the recent concept to be followed, regulations for providing informal care are more and more required.
Introduction
This report aims to illuminate the role of regulation, qualifications, issues of cost, impacts of immigrant workers, on users of health and social care in Greece. The information was retrieved from three different sources, namely from the available literature in the Greek and English language, interactions with commissioners of health, and the testimonies of care service users. The information retrieved included the perspective of care commissioners.

Procedure and findings
Desktop research – A review of the available literature depicts that only 34,000 formal carers are available in Greece (OECD, 2010), comprising in Europe the second lowest ratio per resident (3.4 carers for 1000 residents), and the lowest ratio per doctor (.61 carers for one doctor). This leads health carers to have the lowest unemployment rates (2-5%), though it raises concerns for the proper coverage of care needs in Greece (Kalogiros, 2013), especially in the era were long term care needs are increasing (World Health Organization, 2014). Greece has undergone several financial adjustments programs during the period 2009-15, which has influenced adversely the landscape on health and social welfare, leading further to significant reductions in social benefits (International Federation of Human Rights, 2016).

There is evidence that the economic crisis has resulted in a continuous shift of the care burden from formal structures to the patients’ families (Dalaka, 2014). However, informal care is not regulated in Greece, as no training options are provided by state structures. Some training options are available for certain conditions (e.g., dementia) from private non-profit organization (e.g., Alzheimer Hellas) where some appear sporadically in the context of projects undertaken by NGO’s (Care2work, 2015).

Assuming a care provide role has been linked with financial strains and economic problems, as 1 in 3 does not receive any support from the welfare system, whereas only 10% receives systematic support in this respect. In addition, many of the informal carers have to reduce working hours, quite their job, and do not seek employment at all (Triantafyllou et al., 2006). It is assumed here that the financial crisis has augmented these problematic in the recent years.

Interaction with commissioners of health and social service. – The interviews conducted among formal care givers revealed a great shortage in nurse personnel in state hospitals, as well as a great shortage in medical material. Commissioners of care services stressed the need for care givers to be evaluated frequently, in terms of having received proper and specialized training for their current post, as well as if they possess personality qualities such as empathy) that are necessary for their profession. In addition, they stressed the fact that institutionalization is not very common in Greece, merely because they are not enough affordable institutions. Most are private care facilities, where the majority of patients cannot afford an access to their services. Therefore, most commonly the family assumes the responsibility of long term care. This trend may add to favorable outcomes in terms of dignity in death, as most patients die at home (if they choose so). Though not enough (or not at all in most cases) provision, support or training for informal care givers are provided, leading
to low quality of care provision, health hazards (both physically and mentally) for care givers and recipients, social exclusion, and poor balance or absence of personal life.

**Users of care services** – the co-researchers reported that the care giving services’ users were unwilling to give any interviews. No explanation was offered for this behaviour.

**Conclusions**
The aforementioned findings indicate that major concerns in Greece derive from the absence of any legal framework that regulates informal care, both in terms of qualifications, as well as for supporting the person assuming the care giving role. This leads to a double hazard with severe consequences for informal caregivers’ well-being, as well as to questionable effectiveness in the care giving role.

Another concern derives from formal sector, where the evident shortages in personnel and medical material lead to serious limitation in providing care services. The financial crisis and the implementation of the adjustment programs seem to have affected drastically and adversely the landscape of care giving in Greece, in a degree that (as it was articulated by many commissioners of health) “not even what is necessary can be covered”.

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**Introduction and overview**

The aging of the Italian population is one of the most important socio-demographic phenomena of our time, with important social, cultural and economic implications. According to Istat, Italy is first in Europe for the number of people over 65 years old and third last for the proportion of under 15. Today, more than 21% of the Italian population is over 65 years: it means 13.2 million people in absolute terms, of which half (6.6 million) are more than 75 years old (Istat 2015).

As it has already been highlighted (Barbabella et al., 2013), the progressive aging of the Italian society is not yet concluded and it is estimated that shortly after 2050 we will have 20-26% of the population over 75. According to the projections of the "World Population Prospect: 2012 Revision" of the United Nations, in 2050 those over 65 will be equal to 33% of the Italian population: one of the highest proportions along with that of Japan, South Korea and Spain. The UN predicts that the structural dependency ratio - the ratio of non-active (under 15 and over 65) and active in the labor market (people between 15 and 64 years) - will jump from the current 54.2% to 62% in 2050, meaning that there will be 62 individuals depending on 100 working.

A direct consequence of this scenario is certainly the increase (at least in absolute terms) of that segment of elderly with health and social care needs that require Long-Term Care (LTC). A recent ISTAT work (2014) has produced updated estimates of the number of older people with functional limitations that require care and assistance. It is estimated that more than 2.5 million elderly people have some kind of functional limitations (mobility, autonomy, communication, etc.), with significant peaks in the South (Campania, Puglia, Sardinia, Sicily) and lower rates in Northern Italy. In particular, the most frequent limitations everywhere were those of activities of daily living (Activities of Daily Living, ADL) (1.6 million elderly, the national rate 12.8%), followed by those related to movement (1.3 million, 10.2%) and confinement (1.2 million, 9.4%).

Care is provided through a complex network of formal (institutional care facilities), informal (usually provided by family) and unregulated (grey market, at-home care). The public services, as well known, are able to take charge of only a part of elderly care and these services are mostly allocated only for a few hours a week. The home care model is therefore predominant in elderly care. Care is still often thought to be a private, family, primarily female concern. According to Istat (The reconciliation of work and family report, 2011) in Italy there are about 3.3 million family caregivers who take care of adults (including the elderly, sick and disabled). However, the availability of family caregivers can’t remedy the structural weaknesses of formal care services, both because of the expected increase of elderly with care needs, and the progressive reduction of the number of family caregivers.
Long Term Care in Italy
Elderly beneficiaries of interventions / services (over 65)

<table>
<thead>
<tr>
<th>Type of service</th>
<th>N*</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private home care services (badanti)</td>
<td>1,000,000</td>
<td>7,9</td>
</tr>
<tr>
<td>Integrated home care (public service) - ADI</td>
<td>532,536</td>
<td>4,3</td>
</tr>
<tr>
<td>Residential care for elderly</td>
<td>205,258</td>
<td>1,6</td>
</tr>
<tr>
<td>Municipal Home care services- SAD</td>
<td>169,580</td>
<td>1,4</td>
</tr>
<tr>
<td>Attendance allowance</td>
<td>1,526,058</td>
<td>12,1</td>
</tr>
</tbody>
</table>

The number of elderly people assisted by a caregiver (private home care) can reasonably be estimated at around one million. This is about twice the elderly benefiting from integrated home care services (health and social care), almost five times those in residential structures and almost six times the number of elderly benefiting municipal home care services. Despite the crisis and the loss of purchasing power of households, the private care sector remains an essential response to the long-term care.

*Care work and the impact of migrant care workers*

2.1. The increasing phenomenon of domestic care workers
The Observatory data on domestic workers INPS (National Social Insurance Agency) show that from 1995 to 2014 people regularly employed in this sector increased nearly fivefold. A phenomenon closely linked to the increase of foreign workers, although the presence of Italian workers is growing, a trend which is partly due to the crisis and the need for many families to find a new income.
During 2014 domestic workers who have received at least one pay contributions were 898.429 of which only 38% occupied as domestic care workers (badanti). It is, of course, an underestimated data, for several reasons:

- there are excluded from the calculation those not employed regularly (grey market);
- a great number of workers classified as “colf”\(^1\) may actually also perform activities of care and care for the elderly but do not declare it in order to pay less contributions.

The estimated number of all domestic care workers, also irregular, is based on a process, refined over the years, combining official and informal sources. It is based on a calculation that uses the INPS data on domestic workers, data on foreign nationals (Istat) and those residing illegally (ISMU), as well as the testimony of many stakeholders - in listening to the Caritas centers, unions, in associations, in volunteering, social cooperation, services engaged in guidance and accompaniment to the labor - that help us to focus on the real size of this phenomenon.

To sum up, in Italy there are, approximately, 830 thousand domestic care workers, (a very high number, considering that the employees of the national health Service are about 646 thousand).

About 90% are migrant workers, and the majority of them without an employment contract. It is actually estimated that:

1. More than a quarter (26 percent) work without a regular contract of employment and reside illegally in Italy (216,000 workers);
2. About a third (30.5 percent), legally reside but work without contract of employment (253,000);
3. Finally, there are those who work with a regular contract, which represents 43.5% of the total (361,000).

Therefore, the contractual irregularities affect almost two thirds of care workers operating in Italy.

2.2. The role of migrant care workers

\(^1\) We use to define "badante" the person (care worker) who takes care of elderly (mainly dependent elderly) within the home environment, while the term "colf" refers to those who are used primarily for the care of the house (housekeeper).

From the practical point of view, the distinction between "badanti" and "colf" can be relevant for the classification in a contract category.

In particular, a "colf" with no work experience, can be framed in the first level (Level A), while the "badante" (carer) has to be framed at least in the third level (Level C, super).
‘Carer migration’ is defined as the movement of care workers or immigrants involved in the provision of care assistance to older people. Migrants are already filling the labour gaps and providing essential care services in many European Member States. In Italy the proportion of migrants among the paid care work force is really high. Within the formal sector migrant workers make up a large proportion of available and employed carers. Similarly in an attempt to overcome the shortages and strain of long-term care many families are employing migrant workers within private homes to provide care. This is unregulated but often preferred as it is less expensive than formal care for the recipient and their family and it means that the care recipient can remain at home which has consistently been found to be the preferred place of care for the recipient.

The presence of migrant care workers (MCW) depend on several factors as the type of welfare system (i.e. care), the type of migration regime (i.e. migrant) and the type of labor market (i.e. worker).

Simplifying, the presence of MCW is favored by:

- **Barely regulated welfare and care system.**
  In less controlled welfare regime countries, where there is a large use of cash transfers for dependent people provided without use restriction. The explicit assumption is that these resources have to be used by families to provide care and assistance for dependent people, but it has been “de facto” consolidated the tendency of employing MCW, generally in irregular ways.

- **Little regulated migration regime.**
  The absence of insufficient controls and disregard of the rules results in an acceptance of the migration of low-skilled workers. This is also reflected in the recurrence of measures to "regulate" the position of those who already live and work illegally in Italy. In countries with this type of migration regime, such as Italy, unregulated migratory components appear almost "structural", and this in fact favors a widespread employment model that accepts immigrants on an individual basis without papers.

- **Low-skilled labor market.**
  There are few barriers to accessing the domestic care market – due to it being unregulated – resulting in a saturation of low-skilled labor, with little chance of career progression. As Italy is characterized by very few professionally qualified care services and low migration controls, MCW are predominantly employed in unregulated ways by families or dependent elderly themselves.

The vast majority of migrant care workers come from Eastern Europe (particularly from Ukraine, Romania and Moldova) and South America (mainly Ecuador and Peru). In recent years there has been an increase of MCW from Eastern Europe, particularly Romania, and a simultaneous reduction of those from South America. There is a large part of over 40 women, mothers, whose children reside mostly in the country of origin. This means that many women are "remote mothers" who had to leave their children at home, to the care of their husbands or close relatives. In the literature these children are defined as "white orphans", i.e. children with one or both parents abroad (Mesini, Pasquinelli e Rusmini, 2006; Irs, 2011).

**Legal regulation and qualifications of care work in Italy**

In Italy, 90% of the care workers are migrant care workers, so the regulation of home care work has also to do with the regulation of non-EU workers. Every year, Italy complies with the programme of entry quotas for non-EU citizens, (Article 21 Act on Immigration – Law 286/1998), the so-called "flow decree" issued by the President of the Council of Ministers providing for the maximum quota of foreigners allowed on Italian territory for employment. In the past (2009, 2012), despite there being a strong element of unregulated work, specific decrees have been published aimed at the
regularization of domestic workers and caregivers allowing families, that had illegally employed
foreign workers, to declare the undeclared work, consequently allowing to non-EU workers to obtain
a residence permit thanks to the signing of a regular employment contract.

3.1. Discipline of the national collective bargaining of domestic and care work
Care work in Italy is governed by the Law, n. 33932, 2nd April 1958 and by the care work national
collective bargaining. The collective bargaining agreement governs the domestic care work
relationship and defines the rights and duties of both the employer and the employee as: the grading
and remuneration of workers, working hours and rest periods, overtime and night work, holidays and
vacations, permissions and absences, illness and accidents and all other aspects of the relationship
between the parties. The rules of the national collective agreement are valid for foreign workers with
a valid residence permit for work.

The national agreement frames employees into 4 different levels; each level has two wage
parameters (the superior is called Super). Each level has got a different minimum wage, duration of
the probationary period and automatic career progression.

| Level A: | generic family workers, not involved in the care of people, without professional experience or with professional experience no longer than 12 months. |
| A super level: | a) An exclusively mere companionship tasks to people self-sufficient, | b) Child Care. |
| Level B: | domestic workers who possess the necessary experience and skills for their jobs, even at the executive level. |
| Level B super: | Assistant to people self-reliant. Carries out duties of care to people (elderly or children) self-sufficient, including, if required, the activities related to the needs of food and house hygiene. |
| Level C: | domestic care workers, in possession of specific basic knowledge, both theoretical and technical, that work with total autonomy and responsibility. |
| C super level: | domestic care workers (without specific training) for people who are not self-sufficient. They provide care to dependent persons, including, if required, the activities related to the needs of food and hygiene. |
| D level: | care workers who possess the necessary professional qualifications, covering specific job positions with responsibilities, decision-making autonomy and / or coordination. |
| D super level: | a) domestic care workers (with specific training) for people who are not self-sufficient. They provide care to dependent persons, including, if required, the activities related to the needs of food and hygiene; | b) Director of the house. It carries out management and coordination functions relating to all the requirements linked to the performance of the house. |

3.2 Casual care work
Care work in Italy may also be performed outside of the national collective agreement, for occasional
needs, and be paid through vouchers. The “accessory type” of casual work is a specific type of job
role introduced by Law 30/2002 and Legislative Decree 276 of 2003 and is currently governed by the
Law 92/2012 which aims to regulate the employment relationships that meet occasional needs
otherwise confined in “undeclared work” without insurance and social security protection.

3.3. Qualifications and Certification of competencies
Only in 2012, the Law 92/2012 set the terms for the creation of an institutional system for the validation of experience and certification of skills and competences acquired. In 2013, the Legislative Decree 13/2013 ordered the conceptual framework necessary to its implementation process. Actually, we are still waiting for specific technical guidelines that will be drawn up by the Technical - Scientific Committee. In absence of national guidelines, the methodologies and tools to identify and recognize the competences acquired outside of recognized training courses, have been defined by regions. For example, the Region of Emilia Romagna (Regional Law 12/2003) has set up a Regional Registration and Certification of Skills System (SRFC) covering core professional standards in the repertoire of the Regional System of Qualifications.

The Lombardy Region has formalized the system with specific regulations (Regional Decree no. 8/6563 of 13 February 2008 "Regional Guidelines for the provision of training in the field of vocational education and training and in particular the Third Party" Certification of skills and recognition of training credits") that connects the validation of formal and informal learning in the Directory of professional Profiles and functional acquisition of a training credit or a qualification. Care users views assist in framing skills recognised as important and as a guarantee of the quality of professional performance. Care users perspective has become important only when a gap appeared in the labor market, occupied by immigrants who performed functions with no special professional requirements and for what it was not possible to use existing professionals (e.g. OSS – social and health care operators) as essentially conceived and formed to be used in a context of welfare services (public or private, but, nevertheless, organized).

The problem of "professional reliability" of care workers has been firstly addressed, with the traditional "word of mouth" system and, later, with public programs aimed to raise the level of skills of carers using basic theoretical training programs. But these programs have not become an integral part of the vocational training systems, because of the progressive reduction of public resources and the special characteristics of the care labour market. In addition, the increasing number of carers who had acquired experience "in the field", has focused attention on a theoretically less expensive mode of traditional training in order to ensure the quality of professional services, and the recognition (in terminological but not administrative sense) of skills acquired in non-formal and informal settings.

For instance in Emilia Romagna, the issue of professional qualification had been addressed by defining a program considered "short" theoretical training (120 hours) aimed at acquiring technical and relational skills, certifiable with a "statement of skills" and recognition of credits for accessing to the OSS (social and health care operators) qualification (1000 hours). It was also aimed to offer a possible career path to migrant care workers with a long-term migration project. There are also tools that simply identify and ascertain the accumulated expertise with the main purpose of ensuring the reliability of the care worker. While considering that Italy remained far behind in dealing with these issues, there is an example of a personal certificate for those who work or intend to work in the care sector. It is the ECC - European Care Certificate, released in Italy by AIAS Bologna Onlus partner of EASPD (European Association of the person with disability organizations, service providers). It is, however, a "self-certification" system, not supported by a legal framework recognized at national level.

We are, therefore, in a position where the question of ensuring the quality of professional performance to unconventional employers (families) has firstly led to the activation of traditional training courses and then to the development of certification systems for prior skills. It has also progressively led to the definition of a new job role that, ultimately, could complement those established through formal training programs.
**Issues of Costs and Pay**

4.1. Costs of care services

In Italy, the funding of care services for the dependent elderly comprises three different levels: central, regional and municipal level.

The central government establishes the amount of funds that pass through the regions and are used to finance social expenditure of Municipalities (e.g. the National Fund for non self-sufficiency (Fna) or the National Fund for Social Affairs (Fnps). Always centrally - through INPS (National Social Insurance Agency) - are handled care allowances and other monetary contributions (500 euro) to invalids, civil and deaf blind.

On the second level, the regional one, they are two separate funding channels: one for social spending of municipalities and another for the social and health spending, administered directly by the Region. For social spending, the regions can also identify an annual quota from their own budget - the so-called Social Fund resources – in order to support municipalities for the implementation of services in their territory.

To these public resources must be added a percentage of care users’ co-paying. The revision of the ISEE parameters in November 2014 has brought several new features, including new levels of tax deductions for dependent persons and the equalization of certain welfare benefits to actual income which has contributed to raising thresholds. As consequence, care users have to pay higher fees for health and social care services.

4.2. Care workers payment

Minimum wages of domestic care workers are annually updated and set up by a national commission that includes trade unions and employers at the Ministry of Labour and Social Policy.

The amounts are determined by the categories provided for by the collective bargaining agreement (CCNL).

**MINIMUM WAGE TABLE - 2016**

Valid from 1 January to 31 December 2016

<table>
<thead>
<tr>
<th>Category</th>
<th>Table A</th>
<th>Table B</th>
<th>Table C</th>
<th>Table D</th>
<th>Table E</th>
<th>Table G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohabitant</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td>Days off**</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Cohabitant</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Night-time assistance</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Night-time Presence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Time</td>
<td></td>
<td>Carers working up to 30 hours a week.</td>
<td>Self-sufficient</td>
<td>Not Self-sufficient</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly salary</td>
<td>Hourly earning</td>
<td>Monthly salary</td>
<td>Monthly salary</td>
<td>Hourly earning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>€ 624,65</td>
<td>€ 4,54</td>
<td></td>
<td></td>
<td>€ 655,89</td>
<td></td>
</tr>
<tr>
<td>A Super</td>
<td>€ 738,23</td>
<td>€ 5,36</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>€ 795,01</td>
<td>€ 567,87</td>
<td>€ 5,68</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Super</td>
<td>€ 851,80</td>
<td>€ 596,26</td>
<td>€ 6,02</td>
<td>€ 979,57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>€ 908,60</td>
<td>€ 658,71</td>
<td>€ 6,35</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Super</td>
<td>€ 965,38</td>
<td>€ 6,69</td>
<td>€ 1.110,18</td>
<td>€ 7,20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>€ 1.135,73* (+ € 167,94)</td>
<td>€ 7,72</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To the minimum wage fixed by law, must be added the increment planned for every two years of service performed with the same employer, the board and lodging fee if cohabiting and eventual increases for merit. The minimum wage is less subsidies.

**Undeclared work**

The lack of regulation is fueled by mutual advantage, for families and for care workers. Families pay less and are free from constraints; the carers give up a set of guarantees and safeguards, in exchange for higher wages. The reason of these choices is the excessively high cost of regulation and the lack of a return for the workers:

"I won’t certainly retire here in Italy», «I do not care because I won’t stay in Italy for long” (from interviews with migrant carers)

The latest survey of IREF (educational and training research institute) returns an image of care work that in recent years has become more onerous, two out of three carers work more than the maximum permitted by law and contractual irregularities are widespread. The comparison with the similar survey conducted in 2007 shows dwindling earnings, which the carers try to cope by working more (“the formula is more work for the same salary”).

Talking about regularity means also taking into consideration the “grey area of regularization”. Many stakeholders and voluntary organizations / charitable institutions detect a significant trend of families to support partial regulation only; through the recognition of less working hours than previously requested. However, regulating carers in a lower category leads to a pay less than the minimum due. The prospects for improving employment seem worse.

It has been confirmed by the interviews, because care users complain about the high costs of regulation.

**Emotional management of the relationship with the care users**

Care work is often required for people who have a serious clinical instability and significant support needs. A survey conducted in Genoa on a sample of 270 family caregivers revealed that in almost half the cases the patients are secluded in their houses, in conditions of total self-sufficiency, and nearly one in three is bedridden, or with cognitive problems impairments that prevent them from carrying out vital functions such as cooking, washing, taking medicine. Questioned about the type of activities - divided into home management (clean the house, do the cooking, ironing, etc.), Taking care of the person (dressing, walking, personal hygiene, etc.), Emotional support (entertainment, support psychological support in their affections, support in social relations, etc.) and carry out activities for other family members (like ironing, running errands, etc.) - the care workers put in first place the emotional support to the frail person (elderly or disabled). And it is certainly around the emotional support in the relationship, often in lonely and isolated people, which increases the depth of the workload in many areas of critical care work.

“The main challenges have to do with psychological preparation to deal with this work; finding the right way to care for people, responding to their specific needs” (Ortona, interview n°8).
The main negative aspect is suffering when you lose them...someone dies and a piece of your heart dies with him ...Regardless of their age, even if they are very old, when they die they always leave a terrible void in you. It's hard to do this job, very hard because they are like your family. You suffer for them in the same way you suffer for your parents. When they are young it’s really terrible...(crying) but you have to go on, it’s your job...that’s life” (Ortona, interview n. 9)

It is worth remembering that providing emotional and practical support to caregivers is very important from a psychological point of view. The analysis of ninety-three studies of symptoms of depression among the caregivers and non-caregivers showed significantly higher levels among the first, and an even more significant difference in the case of caregivers of people with dementia (Alzheimer’s Disease International, 2013). From research carried out at national level, it appears that many caregivers are afraid of talking about the fatigue and their negative feelings because people could consider their dependent family members as a burden. Because of these emotional troubles, fatigue, tiredness and negative feelings find little space in their narratives. An attitude which leads to "invisibility of care" work.

The living conditions of foreign domestic helpers, often characterized by occupational segregation, housing and relationships, outlines a strong vulnerability framework. And returning home, at times, it makes the situation worse. As evidenced by Fedyuk, Piperno and Vianello (2013), "the returning migrants in Ukraine are concerned by another form of psychological suffering that is called" Italian syndrome "a depressive crisis caused by the conjunction of multiple traumas (Leogrande, 2011): remote motherhood; the continued proximity with the illness and death of the elderly; heavy working conditions; the loss of their professional identity and the impossibility to valorize what they have learned in Italy (Cingolani, 2011); the erosion of social ties with family members and friends that makes the particularly complicated back experience especially from the emotional and relational point of view (Vianello, 2009) ".

**Conclusion**

The biggest challenge for policy makers is to be able to meet the increasing complexity of the frail elderly with adequate interventions by the health and social protection system, at the same time reconciling the public finances hit by economic crisis, recession and cuts. In Italy the LTC system has traditionally relied heavily on the role of the family, both in terms of informal care provided by family caregivers to dependent person and in terms of private spending that for the direct assistance. But Italy, among the greatest European countries, is the only one not to have reorganized their care system over the past thirty years. For these reasons, the formal system of LTC public in Italy is today faced with the need to reform in a fair, appropriate and sustainable way in the long term, taking into account the demographic, social and economic factors.

What to do?

At the national level, there are two requirements that would have important impact on social welfare.

- Basic levels of care. It is urgent to define the “basic levels of assistance” in the field of social services (LIVEAS). They must be guaranteed at national level. There is a discrepancy between the guarantees offered by a universal public health system and a social system too conditioned by resources and local discretionary regulations.

- Tax relief in taking a family assistant. The tax burden is the primary deterrent for regulating undeclared work. The current rules allow a maximum deduction from taxable income of 1,550 euro and a tax deduction of 400 Euros. Considering that the tax rate may reach a figure eight times higher, it is clear the limited impact of these concessions.
Loneliness and the individual support needs can realistically be reduced through building a personalized plan of actions centered on meeting the needs, accompanying people, connecting them with social and health services. The families not only ask for money but also for services. They ask for support, to be referred to other appropriate services and practical help. After all, it is what emerges from the experience of the social voucher: if we really want to talk about “free choice” in non-ideological way we have to reorient it in “power of choice” and “possibility of choice” and dedicated actions are needed for both.

It is necessary to standardize places that facilitate the matching of supply and demand, front desk activities (information, advice, guidance) and ongoing monitoring of care services (Pasquinelli, 2011; Rusmini, 2011). It is necessary to create a network of circular supportive actions: one-stop-shop services for families and carers, training, registers of accredited care workers, financial support, and assistance in regulating undeclared work.

In other words, there is a need for a multi-level coordination:

1. Coordination between interventions. An economic contribution to the situation is not attractive enough for families, unless it is connected to a set of services. Training is not sufficient if not properly valued in a register and in the subsequent matching. Any intervention (economic support, training, tutoring, etc.) is not effective if it is not introduced across the board and easily accessible. The more one is able to provide coordinated responses, the more efforts will have a centripetal effect; will be able to attract market shares.

2. Coordination between levels of government. In the absence of a “friendly” tax regime for the families, regional and local actions will continue to suffer the handicap of a powerful attractive force by the ‘grey’ market. The lack of consistency between national and local qualifying intervention policies strongly penalizes the efforts under way.

3. Coordination between policies. Encouraging the regulation of undeclared work and improving pay accompanied with the claim of no user constraints, is contradictory. Misaligned policies express contradictory messages.

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Sources of data
The data used in the report come from three sources (in accordance with the guidelines adopted by the partners):

**Desktop research**
It includes data from: scientific studies, Reports of the Central Statistical Office, the publication of the Ministry of Labor and Social Policy, mass media and social networks.

**Interaction with commissioners of health**
Interviews with caregivers dealing with the elderly on the basis of one of the three dominant models (employees of nursing homes, careers not employed under a contract of employment, related careers - family). Additional data were obtained in the course of caring the project for example training for caregivers.

**Users of care services**
Interviews with service users - the elderly, remaining in the care of others (in a formal relationship - residents of nursing homes and informal - individuals under the care of a family or unrelated persons).

Role of regulations
In Poland, as in other European countries, demographic structure is dramatically changing. In 2035 the retired elderly will probably account 1/3 of polish population. Many of them lead single households. It is expected that in 2030 more than half (53%) of households will be carried out by persons over 65 years old.

According to polish law a single person, who because of age or illness requires help, is entitled to care services. When one needs full time care (24 h), seniors can benefit from the nursing home. Nowadays the population of elderly who are entitled to social welfare homes nad nursing homes in Poland is systematically growing. It will be approx. 25% of population within five years.

A significant challenge for the system of care for the elderly is insufficient number of nursing and social welfare homes. With many millions of people who, because of illness or infirmity are unable to live independently, only 85 thousand are staying in public or private nursing home.

There are three main sources of problem on institutional care for the elderly in Poland:

- Limited number of places in nursing homes
- Cost of staying in a nursing home
- Socio-cultural perception of the role of older people in a society

Limited number of places in nursing homes
According to the law, a persons who, because of age, illness or disability need full time care can apply for the care in a nursing house. Such person should find help in a nursing home located close his/her place of residence. Inability to function independently is the key here, because, as it turns out, the house may refuse to accept a person who, despite many illnesses and disabilities can take care of himself/herself. The purpose of this regulation is a reduction of number of residents who are able to live without professional/organized help.

Data gathered during our research under Help care project confirm the problems associated with too many residents and too small space for living in nursing homes (overcrowded rooms, limited space...
makes it difficult to navigate in a wheelchair, lack of privacy and intimacy during the implementation of nursing activities).

**Cost of staying in a nursing home**

The monthly cost of living in state owned (public) social care homes is 2 500-3 500 zloty (625-900 Euro), but sometimes it is necessary to wait even a few years to get a place and help. (The current lowest salary amounts 333 Euro).

The situation results from the fact that a payment is not related to the level of residents’ income. In practice it means that in case of financial incapacity of older person the costs are shared by other entities. It is regulated by the law on social assistance who and how much is obliged to pay for a place in a nursing home. According to this regulation these are the following entities (in order of duty):

- a resident of the social care house,
- spouse, descendants (children, grandchildren) before ascendants (parents, grandparents);
- local municipality, (inhabited by the resident),
- Others, if they notify the desire.

The fees charged for a stay in a nursing is paid by:

- resident of nursing home (up to 70% of his/her income);
- spouse, descendants or preliminary - under contract with home care based on income derived;
- Community - who will pay the difference between the average cost of living in the nursing home and the fees paid by the resident or his/her relatives.

The regulations defining the degree and extent of the financial duty applies only to state institutions. Placing an elderly person in a private nursing home is based on rules set by the receiving entity (under the current legal system). The fee in private care centers is varied. Tuition starts from 1,800 PLN (about 450 Euro, at the current lowest salary 333 Euro net), and ends with several thousand zlotys a month. Everything depends on the standard and scope of care. The high cost of staying in the private care houses causes that they are located mainly near large and wealthy urban agglomerations.

**Socio-cultural perception of the role of older people in a society**

The socio-cultural changes in Polish society influence also the family structure. Poles are now facing the trend from the extended multigenerational families into independent individuals. This means that older people live alone and when it is necessary to provide them with care, this obligation rests with the family. This obligation is treated as a duty, as evidenced by the attitude toward the work related caregivers. Often, despite the daily difficulties they are not looking for other solutions in the field of health, and the only support in its implementation (eg. Institutional support, appoint an additional guardian of the institutions part-time). Adoption by the family's duty of care for the elderly is further reinforced by the limited access to DPS, the inconvenience of their organization and the underfunding of the entire system of care.

Expenditure on social care of the elderly in Poland (0.25% of GDP) are lower than in other EU countries, eg. In Sweden it amounts to 2.7% of GDP, 1.8% in Norway. It also translates into wages of careers of the elderly. Total monthly salary (median) is now 2 160 zloty (480 Euro). Every second career receives a salary from 1 872 to 2 800 zloty (from 420 to 530 Euro). 25% of the worst paid
careers of older people earn less than 1,872 zloty (420 euro). Earnings above 2,800 zloty (530 euro) are received only by 25% of the group of best-paid careers.²

Conditions and solutions described above cause that we have several forms of care for the elderly in Poland:

- Institutionalized form of care (public or private social care/nurse homes);
- Private care from relatives (care of parents or others relatives supplied by family sometimes with the support from institutions - careers appointed by an institution to help an elderly person for a few hours a week);
- Care from unrelated individuals (employment under a contract of employment or much often - due to the significant costs - illegal employment).

Tab. 1. Types of care in Poland

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<tr>
<th>Formal</th>
<th>Unformal</th>
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<td>Public or private social care/nurse homes</td>
<td>Related career</td>
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<tr>
<td>Unrelated, formally employed career</td>
<td>Unrelated career working on a black market.</td>
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Caregivers are mostly women over 35 years old, without education, often performing their work due to the lack of alternatives on the market. The work is a full-time (usually 40 hours per week). It is quite often that one career takes care for several people at the same time.

**Relevant qualifications**

In Poland, none professional certificate is not demanded to become a career. To be employed in a nursing home as a career it is enough to have secondary education. However, in the case of a qualified/professional career in the nursing home, a diploma in the profession of caregiver for elderly is demanded. The study in these occupations takes place at the post-secondary schools and lasts for two years.

It is assumed that the essence of the profession of career of the elderly is to deal with the elderly by helping them in everyday life. Duties of caregivers can be very different, depending on the health of older people, as well as the place of employment. The most common tasks of the caregiver are as follow:

- Help the patients in everyday hygiene (washing, combing, and dressing), feeding, and medication. In case of disable patients, career may also be responsible for the administration of drugs, making injections, dressing, and rehabilitation. Career usually monitors the health of the patient.
- Help in housekeeping (cleaning, washing dishes, laundry, cooking, shopping. Career often deals with various duties out of home (purchasing medicines according to prescriptions, bill payment, arranging transportation).
- Help in organizing an older person’s free time, for example attendance in a training which can help an older person’s physical and psychological development and greater independence.
- Those careers who have the required qualifications can perform operations such as catheterization, service courts, making injections, the administration of medication by a doctor before an unauthorized etc.).

² The data come from January 2016.
Help and assistance for the elder’s family by: providing information on the proper care of the older person, nutrition, ways to facilitate the exercise of daily care.

One can identify two types of care in Poland: assistance for the elderly and care of the elderly.

**Assistance for the elderly** – support in carrying out daily activities, adherence to the company, settling minor matters outside. The research of Polish Centre for Public Research shows that every second respondent (among 75+ years old) declares limitations in completing every day duties. Among respondents aged 60-74 years, every seventh respondent declares the same problem and in the age group of 55-59 years every tenth.

**Care of the elderly** – related to the care of sick people, demanding medical treatment. The research conducted in June 2012 by Polish Centre for Public Research shows deterioration of health self-evaluation among people over 75 years old. The majority of them declare that their health is poor and only every one in ten declare it is well. Among younger respondents subjective assessment of their health is much better - in the age group 60-74 years, every fourth respondent evaluate it well.

Persons interested in working as a care assistant of elderly people can find employment in nursing homes, hospices, palliative care facilities, community self-help. They can also be hired to assist in the homes of people where it is needed.

The basic condition that must be fulfilled by candidates to work in this profession itself is a desire to care for another person. As many older people expect a variety of forms of support and help (as listed above) the main skills and competences which are demanded from caregivers are as follow:

- empathy,
- gentleness,
- understanding of the other person,
- physical power,
- ability to react in crisis situations,
- a basic knowledge of diseases and conditions with which they have the most problems of older people,
- ability to organize time,
- patience and composure,
- stress resistance,
- resistance to situations of suffering and death,
- Ability to accept different culture.

The features listed by the respondents and described in the literature refer both to the career’s job effectiveness and relations between caregivers and older people. As far as the last element is concerned residents underline their expectation and need of empathy. Empathy is the absolute number one on the list. In addition, expectations of older people often refer to the health and care system’s solutions, for example less workload of careers, double-sided adjustment, and the higher remuneration for career’s hard work (which indicates high awareness of working conditions among the patients).

In the caregivers’ opinion, their profession is underestimated and is connected with very low social prestige. The relatively low formal requirements relating to the profession mean that careers, in spite of considerable knowledge and rich experience, are perceived as unskilled workers. The low level of salaries often causes additional burden for caregivers. They underline in each interview that they have to pay physical, mental and social cost for their important and demanding job which is undervalued what is reflected in their remunerations.
Immigrant workers
The socio-demographic in Poland (aging population and the high emigration of Poles) causes that nowadays more and more immigrant’s acts as careers of older people. However, this is mostly illegal employment in private homes. A lot of careers are citizens of the Eastern European countries, in the area of Armenia, Ukraine, Belarus, Moldova, Russia and Georgia. According to polish law system immigrants from these countries are allowed to do this job (caregiving) for six months (within 12 months) without a work permit (a statement of intent to give this kind of work is sufficient).
It should be noted that the system of care for the elderly in Poland requires a thorough analysis and re-engineering. One should take into account the rapid increase of elderly population, the retirement age (which reduces the possibility of dealing with those relatives), increase efforts to improve the quality of life of older people.
As the awareness of coming challenges is increasing, the Ministry of Labor has prepared a document containing assumptions for long-term senior policy in Poland for the years 2014-2020. The senior policy is generally defined as the targeted actions of public administration at all levels and other organizations and institutions which undertake tasks and initiatives creating conditions for a dignified and healthy aging. The aim of the senior policy in Poland is to support and provide opportunities for active healthy aging and giving opportunities for continued autonomous, independent and fulfilling life, even when some functional limitations.
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This project has been funded with support from the European Commission. This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.